A STUDY OF THE RELATION BETWEEN HEALTH ATTITUDES, VALUES AND BELIEFS AND HELP-SEEKING BEHAVIOUR WITH SPECIAL REFERENCE TO A REPRESENTATIVE SAMPLE OF BLACK PATIENTS ATTENDING A GENERAL HOSPITAL

by

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ABSTRACT

There is strong evidence supporting the view that beliefs and attitudes influence health behaviour. Furthermore, cultural and social beliefs also have been shown to influence the way health care facilities are used. Although western medicine plays a dominant role in the mass control of disease, traditional or folk medicine continues to play an important role in the health care of black communities. They therefore, possess unique attitudes, values and beliefs about health and illness which integrally influence their health behaviour.

This study aims therefore to: understand phenomenologically the urban African's perception of illness, disease and health; identify attitudes that directly influence health behaviour: identify "trigger factors" that precipitate health action and isolate factors that contribute to "negative" health behaviour.

The sample in this study consisted of 3 groups of urban Africans who were 20 years and older. Group 1 comprised first time attenders to a medical outpatients department Group 2 and Group 3 were sample groups drawn from the Umlazi Township and the Kwa Mashu Township respectively. The Health and Illness Battery in the language of the participants were administered by trained interviewers.

This study has demonstrated the following: urban Africans have a personal conception of illness, health and disease that influences their manner of help-seeking; there are certain attitudes and beliefs that directly influence both positive and negative health behaviour;. there are several health beliefs which interact in a complex way and may lead to medical help-seeking. Health action was found to be influenced by significant individuals in the subject's environment; demographic variables, such as, age, sex, education and urbanisation strongly influence the health and illness beliefs; these results validated some of the

fundamental aspects of the common western health and illness models; the use of services and facilities are determined by the location, accessibility and the quality of services; financial costs, time, transport, lack of community supports, negatively affected help-seeking; symptoms have been identified as a “trigger factor” of help-seeking. Individuals use other forms of treatments independent of medical treatments. A model of help-seeking for urban Africans is proposed.

PREFACE

This study represents original work by the author and has not been submitted in any form to another University. Where use was made of the work of others it has been duly acknowledged in the text.

This research described in this thesis was carried out at King Edward VIII Hospital, Durban, South Africa and in the Sub-Department of Medically Applied Psychology, Department of Psychiatry, Faculty of Medicine, University of Natal, under the supervision of Professor L Schlebusch.

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GLOSSARY

χ^2	Chi Square
ANC	African National Congress
ANOVA	Analysis of Variance
CAT	Computerised Axial Tomography
df	Degrees of Freedom
Dx	Disease
ECG	Electrocardiogram
EEG	Electroencephalogram
HBM	Health Belief Model
HBQ	Health Belief Questionnaire
HIB	Health and Illness Battery
HIQ	Health and Illness Questionnaire
IFP	Inkatha Freedom Party
Km	Kilometre
LES	Life Experience Survey
MANOVA	Multivariate Analysis of Variance
MEDUNSA	The Medical University of Southern Africa
Mn	Mean
MRC	Medical Research Council
NAMDA	National Medical and Dental Association
NEHAWU	National Education, Health and Allied Workers Union
p	p value
PASA	Psychological Association of South Africa
SD	Standard Deviation

SI	Symptom Inventory
SSQ	Social Support Questionnaire
USA	United States of America
Rx	Treatment

Zulu words used in this thesis are explained in the text.

Both the terms "black" and "African" will appear in this thesis and refer to Black South Africans. "Black" is used in instances, such as, "black groups" or "black community" and "African" is used mainly in references to the traditional African world-view and to aspects of African cosmology, as in, "African medicine", "African illness" and "African healers".

CHAPTER 1

INTRODUCTION

The health system of South Africa has received heightened attention both locally (Daily News, 9 March 1990; National Medical and Dental Association [NAMDA], 1987), and internationally (Andersson and Marks, 1988; Zwi, Marks and Andersson, 1988), largely because it has been strongly influenced by the political system in the country based on racial separation. The health services here are a combination of both First and Third World medical practice. The solutions suggested with regard to the unification of health departments and the improvement of the health system have mainly dealt with issues such as political change, the sharing of political and economic power and the equalization of education, housing, employment and wages. All these changes have direct consequences for the health care (Price, 1988) and would have the effect of equalizing health care facilities and overcoming present obstacles to effective care, such as, the affordability of health care and the maldistribution of health workers and facilities.

But there is another, less obvious, obstacle that endemically affects the care and healing process which cannot be ignored in the present concern to improve the health system. For the majority of the South African population, who are black and socially disinherited, the practice of western medicine is “alien” in many ways. This grossly neglected area has to do with an aspect of the psychological dimension of health and is the subject of this study. In order to obtain maximum utilisation and benefit of the health system it is of

prime importance to understand the black patient's view or psychological perception of health and illness. Although western medicine plays a dominant role in the mass control of disease, traditional or folk medicine continues to play an important role in the health care of black communities here and in the rest of Africa. Individuals, in black communities, therefore, possess unique attitudes, values and beliefs about health and illness which integrally influence their health behaviour. Health behaviour, according to Stone (1979), is a generic term used to refer to "all molar behaviour that is guided by health purposes or reinforced by health outcomes" (p. 24). Kasl and Cobb (1966a, 1966b) suggest that health behaviour can be differentiated into preventative health behaviour (actions taken to prevent illness), illness behaviour (actions taken after symptoms are experienced) and sick role behaviour (actions after diagnosis). [These categories of health behaviour will be dealt with in greater depth in Chapter Two].

There is strong evidence supporting the view that beliefs and attitudes influence health behaviour. For example, Lewis et al. (1976) and Mechanic (1976a, 1976b, 1976c) have shown that health care facilities are directly affected by factors such as dominant belief about illness and the stigma associated with seeking help. The clinical diagnosis of illness is not always related to the patient's subjective response to their symptoms and "feeling better" may be associated with events which are quite independent of professional treatment (Knowles,1977). [These aspects are explored further in Chapter Two under "Beliefs, Attitudes and Values"].

The way individuals interpret their symptoms of an illness is an essential step in the process of seeking help and of the healing process itself. Frequently, these interpretations have led to many symptoms either being ignored or going untreated (Mechanic, 1978; Pennebaker, 1982; Roghman and Haggerty, 1972). Bishop's study (1984) of lay responses to illness (refer to Chapter Two, sub-section "Health, Illness and Disease" for definition of illness) illustrated the problem of serious symptoms going unnoticed because they fell out of the purview of the patient's interpretation as to what was going on. [This aspect of symptom interpretation is dealt with in Chapter Two under "Symptom Interpretation and Health Behaviour"].

Furthermore, cultural and social beliefs also have been shown to influence the way health care facilities are used. Ngubane (1977), in discussing models of illness among Zulus, noted the distinction made in Zulu society between illnesses that are universal and treatable biomedically (*umkhuhlane*) and those which may require ritualised and indigenous methods of healing (*ukufa Kwabantu* - "disease of the African people"). This distinction between "African" and "non- African" illnesses is often alluded to (Cheetam and Cheetam, 1976; Edwards et al. 1983; Wessels, 1984a). However, as Mills (1983, 1985) indicates, some illnesses such as tuberculosis may be understood purely biomedically in some contexts and as having African elements in others. Ngubane (1977) observed that the concepts of ecology are central to the Zulu idea of health. Explanations of ill health may often lie in interpretations of environmental imbalances created by sorcery (*ubuthakathi*) or disturbances in the social order. [These aspects and the role of culture are treated more fully in Chapter Three].

It appears that a great deal of the health care occurs quite independently of the formalised health care system (Christman and Kleinman, 1983). According to Mills (1985), there is a range of non-formal and socio-cultural resources for illness management available in communities. Popular health care (given by family, friend and other members of the community) and folk medicine (which include the formalised cultural experience of healing, faith healers, traditional healers and priests), are still considered more significant than the formalised western health services.

The attitudes that people hold about health are clearly important to health care itself. Some researchers have even argued for differing modes of services based on different views of illness (Millon, 1982). Changes in the attitudes of health and illness will, in turn, have a direct effect on the healing process itself. One example is the "germ theory of illness" which directly led to changes in the attitudes to the use of sterile medical procedures, improvement of sanitation and personal hygiene (Clymer et al., 1984). [Cultural, popular and folk medicines are discussed in Chapter Three together with certain other related issues].

Although there is an abundance of research into this aspect of health care world-wide, very little has been done in African communities, and this dearth of researched information is true for South Africa as well. In this study, therefore, the focus is on the relation between health attitudes, values and beliefs and a specific area of health behaviour, namely, "help seeking behaviour" or "health action" in urban Africans. The attempt is also made to gain an understanding of urban African beliefs, attitudes and values about health and illness and to see how these beliefs, attitudes and values influence their health behaviour as well as the use of health care facilities. In addition, related urban African health and illness issues, such as, symptoms and symptom interpretation, the influences of cultural and social beliefs on the use of health care facilities, the role of popular health care and folk medicine, the role of social support in the seeking of medical help and the effects of life changes or stresses on help-seeking are also investigated. In this connection, the existing health and illness models are compared and an African model for help-seeking behaviour is proposed.

A study of this kind has direct relevance for both the South African context and other "Third World" countries. It will assist in the development of health education programmes; planning of health facilities; the timeous promotion of health action; the control of disease and the raising of the health status of the population. However, it is its contribution to medical psychology that is the immediate objective. I have been especially interested in its direct benefit for clinical psychologists, especially those like myself who work in a general hospital setting like the pioneering Sub-Department of Medically Applied Psychology unit at the King Edward VIII Hospital in Durban, South Africa.

In summary, this study aims to:

1 understand phenomenologically the urban African's perception of illness, disease and health;

2 identify attitudes that directly influence health behaviour;

3 study the relationship between the key attitudes that influence health behaviour, and other relevant environmental, social and psychological factors;

4 identify “trigger factors” that precipitate health action;

5 isolate factors that contribute to “negative” health behaviour;

6 assess the validity of existing models of health and illness for the sample studied; and

7 understand the process underlying the association of symptoms to disease and the interpretations given to symptoms (i.e. the understanding of illness).

In order to achieve the above aims, the following hypotheses will be tested in a representative sample of urban Africans drawn from both a clinical and general population:

1 that the subject's personal conception of illness strongly influences the manner or way of seeking help;

2 that certain attitudes directly influence positive and/or negative health behaviour;

3 that certain events in the subject's environment contribute to the seeking of help; and

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Trigger factors refer to factors, such as, circumstances, events, cognitions or sensations.

4 that health action is influenced by significant individuals in the subject's environment.

This thesis is organised in the following way. In Chapters Two and Three necessary background information and a review of the pertinent literature is presented. Chapter Two also provides a brief history of psychology and its involvement in health and illness as well as a description of various terms and definitions that have emerged from this relationship. Also provided in this chapter are definitions of the psychological concepts in health and illness that will be used throughout this thesis. To provide some perspective on health-related behaviour a review of some of the more popular theoretical models of health-related behaviour follows . Finally, a review of some of the critical issues in health behaviour are provided.

Chapter Three deals with issues specific to the South African context. These include issues such as health in South Africa, cultural influences on health with special reference to the aetiology of illness in the African world-view and traditional treatments.

In Chapter Four the methodology of this study is presented. A description of the subjects, the selection of the sample and the materials used in the study are then described. Other issues, such as, the choice of the questionnaires used, the validation of the questionnaire and problems experienced together with available measurements follow.

The results and the analysis of the data appear in Chapter Five. The results are presented mostly in tabular and, wherever necessary, in graphical form (Briscoe, 1990), in the order it was obtained from the Health and Illness Battery (HIB) so that they are easily comprehensible and allow for easy comparison. The results section summarises the data collected and their statistical analysis.

In Chapter Six, the discussion section, the main findings are examined and interpreted. Finally, the main conclusions and the theoretical implications of the study are presented.

See chapter four “Method of Data Collection” for a description of the HIB.

CHAPTER 2

PSYCHOLOGY AND HEALTH

Although the history of psychology may be traced to the period of early civilisation (Kimble and Schlesinger, 1985a, 1985b), as a scientific discipline it covers a period just over a century (Brennan, 1986). Like many of the other sciences, psychology originated in philosophy and emerged as a separate discipline in the late nineteenth century. It was initially concerned with sensations and perceptions but thereafter moved to the study of human behaviour and became more “applied”. One of the first applied sub-specialities was clinical psychology. Although the beginning of clinical psychology is marked by the founding of the first American psychological clinic in 1896 by Witmer, it was only in the 1940's that it become a well organized and recognized academic discipline. In the early 1970's further specialization took place within psychology with psychologists becoming more involved in areas of health and illness. This involvement, however, should not be construed as a totally new phenomenon but rather as a re-newed interest.

The combined role of priest and healer, philosopher, scholar and teacher, however is much older and remains a phenomenon still common in traditional societies and in the practice of traditional medicine (Schlebusch, 1990).

Psychologists' interest in health and illness has led to new challenges and opportunities and has contributed to a transformation of their traditional role. Howard et al. (1986) noted that 53.2 percent of new psychology doctorates in 1984 were in the health service provider subfields. These authors also point out that not only has there been a dramatic rise in the employment of psychologists in the health service, but that there has also been a related decline in their academic and research roles. Further evidence for this overall rate of growth of psychological interest in the area of health is the increased employment

of psychologists in medical and health care positions; the rise in membership to bodies such as The American Psychological Association in the divisions of Health Psychology and Neuropsychology; the increase in the amount of literature published in the area and the rise in the number of psychologists employed at medical schools (Gentry and Matarazzo, 1981; Millon, 1982; Sweet, et al.1991). Similar changes have occurred in the United Kingdom as well (Nicholas, 1983).

In South African a similar trend is taking place. There has been the development of clinical psychological services in general hospitals (Schlebusch, 1983a, 1983b; Schlebusch, 1987; Schlebusch, Pillay and Louw, 1989; Pillay, Schlebusch and Louw, 1992); the training of interns in clinical psychology at general hospitals (Schlebusch, 1983b, 1989); the establishment of teaching programmes at medical schools in medical psychology, clinical health psychology and behavioural medicine (Schlebusch, 1989); the development of employment opportunities in these areas and planned future development in academic hospitals (Schlebusch, 1987; 1989). However, these developments vary considerably within the country (Schlebusch, 1989, 1990). In some provinces, for example, Natal, a fairly well established service exists in hospitals, such as, King Edward VIII Hospital (a large teaching hospital attached to the University of Natal Medical School) and Addington Hospital. The Natal University's Medical Faculty was the first South African medical school to establish a department of a Medically Applied Psychology with the appointment of a full professorship in this field (Schlebusch and Wessels, 1986). Elsewhere in South Africa, clinical psychology at the teaching hospitals operates within the Departments of Psychiatry with principal psychologists as clinical heads. An exception is The Medical University of Southern Africa (MEDUNSA) in Garankuwa, which has two departments of psychology. One of these departments teaches general psychology and the other trains clinical psychologists. More recently, the Psychological Association of South Africa (PASA) felt it necessary to develop a Division of Health Psychology.

Not only are psychologists from all sub-disciplines (e.g. clinical, social, academic, etc) showing a greater interest in health and illness, others, such as, social workers, occupational therapists, psychiatrist and medical practitioners are also showing a growing

interest in psychological principles and concepts for their work. Their emphases and practices naturally vary. The attempt by these inter and intra-disciplines to define their work has led to a plethora of terms and definitions; For example, “health psychology”, “clinical health psychology”, “medical psychology”, “behavioural medicine”, “psychological medicine”, “psychosomatic medicine”, “behavioural health” and “health behaviour”. The similarities and distinctions between these terms are not always clear and at times they are inappropriately used. Broadly speaking, these areas can be divided into those that are discipline-specific and those that are multi-disciplinary (Schlebusch, 1990). Areas such as psychosomatic medicine, psychological medicine and consultation-liaison psychiatry are all sub-specialities of psychiatry and usually involve professionals trained in medicine and/ or psychiatry. Clinical psychology, rehabilitation psychology, health care psychology, general hospital psychology, neuropsychology and health psychology are specific to the discipline of psychology and involve professionals trained in psychology. Other areas such as behavioural medicine, behavioural health and health behaviour are multidisciplinary. Some areas are broadly defined while others are much more specific. For example, *health psychology*, which is discipline specific, is defined as:

> the aggregate of the specific educational, scientific and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiologic and diagnostic correlates of health, illness and related dysfunction, and the analysis and improvement of the health care system and health policy formation (Matarazzo, 1982, p. 4).

It is evident from this definition that health psychology embraces any activity of psychology relating to any aspect of health , illness, health care system or health policy formation. Clinical health psychology, on the other hand, is more specific, accentuating the significant relationship between clinical psychology and health psychology (Schlebusch, 1990).

In some instances, health psychology is sometimes erroneously used to refer to behavioural medicine. This is grossly inaccurate since *behavioural medicine* according to Schwartz and Weiss (1978) is defined as the

> interdisciplinary field concerned with development and integration of behavioural and biomedical science, knowledge and techniques relevant to the understanding of physical health and illness and the application of this knowledge and these techniques to prevention, diagnoses, treatment and rehabilitation (cited in Gochman, 1988).

Essentially, behavioural medicine is the 'interface' of the behavioural and biomedical sciences.

An emerging interdisciplinary field which is still in the process of establishing its identity and which is particularly relevant for this study, is *health behaviour*. A more concise definition than that used earlier (Stone, 1979) is that of Gochman (1982) who defines health behaviour as

> those personal attributes such as beliefs, expectations, motives, values, perceptions and other cognitive elements: personality characteristics, including affective and emotional states and traits; and overt behaviour patterns, actions and habits that relate to health maintenance, to health restoration and to health improvement (p. 169).

According to Gochman (1982) the word "behaviour" refers to something that people do or avoid doing and is not necessarily consciously or voluntarily done. This definition excludes treatment, reflections of bodily states, clinical improvements or physical recovery or health status. A person's perceptions of his/her health status or of improvement, recovery or other changes in health status are also regarded as health behaviours. This definition also includes "not only directly observable, overt actions but also those mental events, feelings and feeling states that are observed or measured indirectly" (Gochman, 1982). In addition, according to this definition these attributes are understood to be influenced by family structure, the peer group and social factors, and social, institutional and cultural determinants.

Health behaviour, therefore, is not synonymous with behavioural medicine although some aspects are common to both. According to Gochman (1988) the basic paradigm proposed for behavioural medicine is the medical model, whereas health behaviour is defined independent of pathology, diagnosis and treatment of specific disorders but includes concern for general health maintenance and well being. It does not automatically begin within a medical framework or its assumptions. Health behaviour does, however, encompass related concepts such as "preventative" and "protective" illness and sick-role behaviour.

2.1 PSYCHOLOGICAL CONCEPTS IN HEALTH AND ILLNESS

2.1.1 HEALTH, ILLNESS, AND DISEASE

Although very widely used, the concepts *health, illness and disease* are very difficult to define since they have been interpreted quite differently among lay people and scholars (Schlebusch, 1990). Inspite of the varying uses of these terms, Diaz-Guerrero (1984), in search for a universal conception of health, studied the responses of subjects in a sample drawn from thirty different cultures and found that there is some cross-cultural agreement that health is characterized as "good", "potent" and "active".

"Health" is frequently considered to be a normal condition, implying an absence of disease, symptomatology or laboratory abnormalities. Such a view which accentuates the absence of biomedical symptomatology constitutes a negative concept of health. Schlebusch (1990) suggests, in contrast, a more positive concept of health in which psychosocial variables play a central role. These variables *inter alia* include education, social class, diet, income, social and occupational environment, life-style, interpersonal relationships, personal habits, access to health care and occupational functioning. Such a positive concept of health, he believes, will facilitate a more comprehensive approach to the delivery of health, unlike the traditional medical model and its concept of disease

which tends to focus on diagnosis and the cure of disease to the neglect of prevention of disease and maintenance of good health.

Even “disease,” which has been narrowly defined as “a medical hypothesis that implies particular pathological processes underlying a specific syndrome” (Mechanic, 1978, p. 25), is now increasingly used to refer to behavioural and social processes for which no such specificity can be demonstrated (Schlebusch, 1990). Often the terms “illness” and “disease” are used interchangeably. One way of distinguishing “disease” from “illness” is to regard the former as a “condition”, and the latter as a “behaviour”. However, as already mentioned, the terms are used interchangeably because of the psychological interplay between them (Schlebusch, 1990). In essence, disease is characterized by structural or physiological, functional and biochemical changes and refers to a biological process. Its basic characteristics remain the same regardless of when or where the disease occurs (Schlebusch, 1989).

“Illness”, on the other hand, implies a subjective, psychological and social experience which is therefore open to interpretation by both patients and the society they live in. In fact, illness may occur in the absence of disease. In contrast, there are times when disease may be present but the patient may not feel ill. This is sometimes referred to as the “preclinical phase of disease” (Braunstein, 1981). According to Cott (1986), illness often remains subsequent to optimal medical treatment and, therefore, constitutes a significant health-care problem. In addition, illness brings a specific meaning to a patient's life and crystallizes special meaning that constitutes and expresses itself as a way of life (Kleinman, 1986). It is because of these idiosyncratic elements and the orientation towards problems of existence and coping that prompted Hunt (1988) to suggest that the measurement of illness must be directed towards the patient's viewpoint.

Gochman (1988) points out six elements that contribute to the complexity and difficulty in defining these concepts. The first element he attributes to the “simultaneous existence of lay and professional or scientific definitions.” Although they overlap there are also differences which have important life or death relevance in the area health. The second

element is the “existence of multiple professional or scientific definitions.” For instance, the medical definitions emphasize the presence or absence of pathology while psychological definitions emphasize perceptions, feelings of well being and equilibrium. The third element is the “plural definitions within each profession (p. 8).” . The acknowledgement that at least three dimensions, namely, the biomedical, personal and socio-cultural must be taken into account, constitutes the fourth element of difficulty in definition. The fifth element affirms that, because of the importance of these three dimensions, there are varying degrees of juxtaposition, conflict and equilibrium among the medical, personal and social perspectives. The last element refers to the simultaneous existence of several different health practice systems; these include “scientific” medicine, religious or “traditional” medicine, public health practice and folk medicine.

2.1.2 SOME SPECIFIC TYPES OF HEALTH BEHAVIOUR

Kasl and Cobb (1966a, 1966b); Mechanic (1978, 1986); Suchman (1972) and Parsons (1951) have made certain critical distinctions between the various types of health behaviours. These distinctions in definitions of health-related behaviour are discussed below.

2.1.2.1 Preventative Behaviour

According to Kasl and Cobb (1966a), preventative behaviour refers to the actions of individuals who believe they are well (i.e. not experiencing any signs or symptoms of illness) in order to remain well. Such a view confines health behaviour to preventative activities and include, but is not limited to, "everyday" nonmedical behaviours such as, duration of sleep, eating habits, weight management, physical and recreational activity, non-consumption of alcohol and non-smoking (Belloc and Breslow, 1972). Primary preventive medical behaviours include behaviours such as immunization against infectious diseases, while secondary preventive medical behaviours will include periodic medical examinations and screening for medical problems. These measures do not necessarily prevent disease but contribute to its early detection (Gochman, 1988).

2.1.2.2 Health Protective Behaviour

Health protective behaviour refers to the actions of individuals that augment primary and secondary preventative behaviours and are directed towards protecting their health, whether medically approved or not (Harris and Gutten, 1979). Examples of health protective behaviours are praying, repairing household implements, consuming large doses of vitamins, taking laxatives, emetics, enemas and cold showers. The common rationale of these behaviours is that they protect and maintain health (Feuerstein, Labbe and Kuzcmierczyk, 1986).

2.1.2.3 Illness Behaviour

The actions of individuals to ascertain their state of health, that is, when they are not sure that they are well or are troubled by feelings or sensations that they believe may be signs or symptoms of an illness are regarded as illness behaviour (Kasl and Cobb, 1966a). Examples of illness behaviours are responses to physical symptomatology, seeking expert

help and advice (either from health care professionals or lay and folk therapists), seeking the opinions of friends and relatives, as well as delaying action to see if the signs or symptoms remit (Gochman, 1988). According to Mechanic (1978), illness behaviour has several determinants including the perception and severity of symptoms, their disruptive and persistent nature, individual needs, the availability of alternative interpretations and treatment, as well as costs in time and money incurred by the individual. These are discussed in greater detail when Mechanic's (1976a) model of illness behaviour is given fuller treatment below.

Illness behaviour also involves help-seeking behaviour (Mechanic, 1986) and manifests when patients' decide to do something about their symptoms or distress. Help-seeking behaviour includes not only the consulting of a medical doctor but also the soliciting of general help from community advisers, tribal authorities, traditional faith healers, the sangoma (diviner) or ministers of religion.

It is, therefore, important to bear in mind that the patient's behaviour in preventing and dealing with illness can be viewed in the context of the patient's own representation of the illness, which is based largely on the experience of certain concrete symptoms. The self-understanding of these symptoms and the nature of the patient's own representation of the illness is naturally open to socio-cultural interpretation as well. However, this self-understanding of illness acts as a regulating system to guide coping behaviour and to set goals through which coping is evaluated (Laventhall et al. 1980) and is powerfully present even during the formal scientific process of healing. The psychological implications of this are obvious.

2.1.2.4 Sick Role Behaviour

Sick role behaviour refers to those actions adopted by individuals who have already been designated sick, either by others or themselves, in order to get well (Kasl and Cobb, 1966b; Parsons, 1951). Examples of such behaviours are compliance with a prescribed

medical regimen, limitation of activity and actions related to recovery and rehabilitation. Sickness is closely allied to sick role behaviour as it generally refers to socially sanctioned ways that infer illness; it is not necessarily implied by illness or disease and can be observed in the absence of either (Hunt, 1988). It involves various behaviours including labelling, communicating distress, seeking medical advice, absence from work and staying in bed. (Schlebusch, 1990).

2.2 HEALTH BELIEFS, ATTITUDES AND VALUES

The socio-cultural attitudes, values and beliefs of a person guide and influence his or her perceiving, filtering, interpreting, understanding and predicting of news, information and day to day events. Hermeneutical understanding, in other words, may be influenced by both cognitive and non-cognitive processes such as perceptions and values. Similarly, as mentioned earlier in the introduction, the attitudes, values and beliefs of individuals about health and illness influences their health behaviour as well.

'Attitude' is most central in social psychology. An attitude may be defined as a "predisposition to feel, think and act towards some object, person, group or event in a more or less favourable or unfavourable way" (Richardson, 1980, p. 299). According to this definition attitudes are made up of three components — cognitive, affective and behavioural. Beliefs constitute the *cognitive* component; attitudes form the *affective* component and the actions constitute the *behavioural* component. Each of the three components may vary in intensity and complexity.

Attitudes derive from underlying values. A *value* may be defined as a basic attitude towards certain broad modes of conduct, such as, courage, honesty, friendship or certain states of existence , for example, equality, salvation and freedom . Values are thus akin to attitudes but they refer to the ends and not the means.

2.3 MODELS OF HEALTH-RELATED BEHAVIOUR

Over the past four decades, several theoretical models have been proposed in an attempt to explain or account for health behaviours. Cummings et al. (1980) have identified fourteen models which they regard as "most notable in terms of predictive ability and frequency of citation" (p.124). A review of all fourteen models are neither within the scope of this study or necessary for its objectives. The following section will briefly highlight a few of the more frequently used models.

A model (or paradigm) is a system of beliefs about the structure and workings of reality. Kuhn (1962) pointed out that models define the legitimate problems and methods of a research field for succeeding generations of practitioners. A model, he held, guides and limits observation. As a model is used anomalies emerge when explanations do not quite fit reality and theories lose their explanatory value. Anomalies emerge when the legitimacy of explanation leads to the search for new ways of explanation. There is often a period of competing models until one dominates to achieve widespread legitimacy, sufficiently enough to become the prevailing paradigm. It is the emergence of anomalies that force one to seek alternate models.

For our purposes we see models as complex hypotheses that attempt to explain health and illness behaviours. All of the models discussed below, except social learning, were specifically developed as health models.

2.3.1 THE HEALTH BELIEF MODEL

The Health Belief Model (HBM) was developed in the early 1950s by a group of social psychologists (Hochbaum, 1958; Rosenstock, 1974) in the Public Health Service of the United States of America in order to understand why people failed to accept "disease preventatives and screening tests for early detection of asymptomatic diseases " (Rosenstock, 1974, p.328.). It was later used to understand sick role behaviours, illness

behaviours and compliance with prescribed medical treatment (Wallston and Wallston,1984). The components of the model emerged out of well established psychological and behavioural theories that hypothesize that behaviour depends mainly on two variables: the value placed by the individual on a goal (ie. desire to avoid illness or to get well) and the individual's belief that a given action will achieve the goal (that a specific health action will prevent or ameliorate the illness). The HBM consists of the following dimensions:

(1) *perceived susceptibility* which refers to an individual's subjective perception of the risk of contracting an illness;
(2) *perceived severity* — this refers to the feelings concerning the seriousness of contracting an illness;
(3) *perceived benefits* refer to the beliefs regarding the effectiveness of the various actions available in reducing the threat of disease; and,
(4) *perceived barriers*— these are the potential negative aspects of a particular health action which may act as impediments to undertaking the recommended health behaviour. These 'barriers' include side effects, pain, inconvenience and time-consumption.

The HBM assumes that there is a "cue to action" that may trigger of the decision-making process and may be either internal (ie. symptoms) or external (eg. media and interpersonal influences). This model accepts that diverse demographical, socio-psychological and structural variables may affect the individual's perception and, as a result, influence health-related behaviour (Janz and Becker, 1984).

Although this model is widely accepted by health researchers, it has elicited criticisms as well. Haefer (1974) described the HBM as "a confusing melange of inconsistent (though by no means disconfirming) results obtained under widely varying conditions and susceptible to no univocal interpretation". At present there are so many variables that have been identified that the theory becomes untestable and unable to be falsified, an important criterion for the validation of a theory say Wallston and Wallston (1984) following Karl

Popper's (1959) 'falsification principle.' In addition, essential elements identified by this model, such as, demographic, structural and attitudes, do not always predict as expected. The lack of specification of relationship among the variables results in relative predictions rather than quantitative ones (Stone, 1979). Another problem is the lack of consistent operationalization of variables which result in different measures being used in different studies. While this variation may enhance the adaptability of the model, it makes comparisons between different studies difficult, if not impossible.

2.3.2 KASL AND COBB'S MODEL

Kasl and Cobb (1966) have formulated two models, one for "health" and another for "illness" behaviours. These models share some similarity with the HBM. The variation, according to their model, is the possibility of an individual undertaking a specific behaviour in the presence of particular symptoms. Furthermore, these models take particular cognizance of factors, such as, pain, discomfort, psychological distress, personal tolerance for pain, disability, coping mechanisms and socio-demographic characteristics.

This model of health behaviours hypothesizes that behaviour occurring in the absence of symptoms is influenced by the threat of disease and beliefs concerning the value of health action. Social characteristics and knowledge are seen as influencing both the perceived threat and health action. Other factors that influence behaviour include the past utilization of medical services, the cost of health action, the cost of inaction and the probability of the health action resulting in the desired outcome.

The model on illness and sick role behaviours hypothesizes that behaviour undertaken in the presence of symptoms is influenced directly by the individual's perception of the threat of the disease and the belief concerning health action. Pain and discomfort are seen as influencing an individual's perceptions as well as directly influencing behaviour. Social characteristics, personal tolerance for pain, disability, and coping mechanisms are assumed to affect behaviour indirectly . The 'threat' component includes the perceived

importance of health, perceived susceptibility to illness and severity of the consequences. The 'value' component includes the probability of action leading to a desired outcome and the differential ratio of the cost of action to the cost of not taking action.

2.3.3 SUCHMAN'S MODEL

This model (Suchman, 1965a, 1965b) results from the efforts to adopt a sociological perspective to understand an individual's decisions with respect to the utilization of health-services. Health behaviours are examined within their social and cultural contexts and hypothesized links are made between specified health orientations or behaviours and social relationships or group structures. Central to this model are the social patterns of illness behaviour. There are four principal factors influencing illness behaviour:

1. *Content* — which involves a series of concepts facilitating descriptions of alternative behaviours and their outcomes. For example,

(a) *shopping* — the seeking of medical care from different providers;

(b) *fragmentation of care* — receiving medical care from different providers at the same source;

(c) *procrastination* — delay in seeking care subsequent to the observation of symptoms;

(d) *self-medication* — self -initiated use of therapies; and,

(e) *discontinuity* — interruptions in the treatment or process of care.

2. *Sequence* — this factor is divided into five transitional stages:

(a) symptom experience;

(b) the assumption of a sick role;

(c) medical-care contact;

(d) dependent-patient role; and,

(e) recovery or rehabilitation.

Initially, the dimension of the symptom experience alerts the individual that something is wrong. First, the pain or discomfort or abnormality is experienced; secondly, the physical

sensations or symptoms are interpreted and defined on the basis of their degree of interference with usual social functioning (cognitive dimension); and finally, the anxiety and fear associated with the illness emerge (emotional dimension).

Although, according to this model, the individual will move from the symptom experience to the assumption of the sick role, he or she may decide on alternatives, such as, denying the presence of illness or delaying the seeking of medical help. During the assumption of the sick role, the individual will attempt to reduce the symptoms by self-initiated therapies or treatments while simultaneously consulting family and friends for advice and information. Following the consultation of a doctor to assist with the organic and psychosocial needs (medical-care contact stage), the individual enters into a relationship which involves the acceptance of a prescribed regimen (dependent-patient role stage). During the medical contact stage, however, the patient may neither believe the diagnosis nor accept the recommended treatment and may turn to other sources for help. Further, various factors, such as, physical, administrative, social, psychological as well as the quality of the doctor-patient relationships, may interfere with prescribed treatment during the dependent-patient stage. In the final stage (recovery and rehabilitation) the individual gives up the patient role.

3. *Spacing* refers to the social cohesion of the group to which the individual is a member; that is, the community, friendship and family levels of the individual's social well-being. The degree of social organisation is characterised by the level of ingroup attraction and exgroup exclusion as measured by "ethnic exclusivity" on the community level, "friendship solidarity" on the social level and "orientation to family tradition and authority" on the family level. These three dimensions are combined in an index of cosmopolitan-parochial social structure, where parochialism is defined by high exclusivity, high friendship group solidarity and high orientation to tradition and authority. The health orientation of the individual is seen as a continuum, varying from the scientific (objective, professional and impersonal) to the popular (subjective, lay and personal) based on the "knowledge about disease," "scepticism of medical care" and "dependency in illness." Popular health orientation is characterised by the following dimensions: cognitive (low knowledge about

disease), affective (high scepticism of medical care) and behavioural (high dependency during illness).

4. *Variability* refers to the variations in behaviour during the five stages of illness. These variations affect the progression from one stage to the next.

While Suchman's study (1965a) seems to support a relationship between social support, health orientation and variations in response to illness, other studies (Reeder and Berkanovic, 1973; Geertsen et al., 1975; Farge, 1978) were unable to replicate these findings.

2.3.4 FABREGA'S MODEL

Fabrega's (1973) model uses an anthropological approach to understanding illness behaviour. This model suggest nine stages of information processing which lead the individual to a decision to act in a certain way. It assumes that there are four systems involved in the information processing. These are (a) the *biological system* which focuses on chemical and physiological processes; (b) the *social system* which affects relationships with other individuals, groups and institutions; (c) the *phenomenological system* which is concerned with the individual's state of awareness and self-definition.; and (d) the *memory system* which includes early illness experiences, medical attitudes and beliefs. These systems are opened and inter-joined.

The first two stages of this model deal with the recognition and evaluation of symptoms. In stage one the individual comes to realize the presence of illness or changes taking place and acts to alleviate the perceived illness. At the next stage the negative components of the illness are evaluated on the basis of present and past experiences. This evaluation leads to a negative value being attached to the condition reflecting the danger, disability, discomfort, social stigma and the psychosocial disruptions associated with the illness. In the third stage, a variety of mutually exclusive treatment alternatives are considered.

These ‘plans’ are learned responses based on past experiences with illness ranging from the use of home remedies and patent medicines to lay referrals in order to obtain medical care or healing. Stages four to seven relate to the individuals evaluation of different treatment plans. These include alternatives that will reduce the “disvalue”, the benefits and utility of each action, as well as personal and economic costs of the action. This leads to the eighth stage which is the selection of a treatment plan. In the ninth stage, further processing and updating take place as a result of the treatment plan selected in stage eight. The illness may be relabelled and a recycling of the stages may occur.

2.3.5 MECHANIC'S MODEL

Mechanic's model (1978) focuses on help-seeking behaviour and shows the variation with which different people perceive, evaluate and react (or not react) to symptoms. The emphasis is on what occurs before an individual sees a health-care provider. Mechanic (1978) identifies ten variables that influence “help-seeking.” These are:

1 “the visibility, recognizability or perceptual salience of deviant signs and symptoms;
2 the extent to which symptoms are perceived as serious (that is, the person's estimate of present and future danger);
3 the extent to which the symptoms disrupt family, work, and other social activities;
4 the frequency of the appearance of the deviant signs or symptoms, — their persistence and recurrence;
5 the tolerance threshold of those who are exposed to and evaluate the deviant signs and symptoms;
6 available information, knowledge, and cultural assumptions and understanding of the evaluator;
7 basic needs that lead to denial;
8 needs competing with illness responses;

9 competing possible interpretations that can be assigned to the symptoms once they are recognized; and,

10. the availability of treatment resources, physical proximity and psychological and monetary costs of taking action (including, physical distance, costs of time, money and effort, as well as, costs of stigma, social distance and feelings of humiliation)" (p.268-269).

Variables 2, 3, 9 and 10 closely resemble the basic elements of the HBM. In addition, Mechanic (1978) distinguishes between "other defined" and "self-defined " illness. Both the situations involve lay referral systems. The difference occurs in the "other-defined " category, where the definition of illness originates from others in the environment and the sick person seems to resist the evaluation and may have to be brought for treatment involuntarily, for example, in the cases of psychosis, illness of children and in cases of adult denial of illness.

2.3.6 ANDERSEN'S MODEL

This is a behavioural model (Aday and Andersen, 1974) that has been used widely for assessing medical utilisation. According to this model, health utilisation is dependent upon three components:

1 the predisposition of the family to use health services;
2 the ability to secure services; and,
3 the need for services.

The first component includes information, such as, age, sex, marital status, education, occupation, and health beliefs and attitudes about medical care, physicians and disease (eg. families that believe in the efficacy of medical treatment will seek care sooner and more often). The second component refers to the conditions that "enable" the use of health services or which makes them available, these include, family resources such as

income and medical aid or community resources such as the availability of health services and health personnel, travel times and waiting times. When these two components are present, two factors, (namely, the variation in perception of illness and the manner of response to illness), will determine whether health services are used. Perceived need is measured by both subjective perceptions of illness and the clinical evaluation of illness.

2.3.7 SOCIAL LEARNING THEORY

The social learning theory was developed by Rotter et al. (1972) to explain human behaviour in complex situations. There are four basic constructs to the theory, namely: behaviour potential (**BP**); expectancy (**E**); reinforcement value (**RV**); and, the psychological situation (**S**). According to the theory, a specific behaviour (**BP**), occurring in a given situation (**S**), is the function of the expectancy (**E**) that the behaviour will lead to a particular reinforcement in that situation and the value of the reinforcement (**RV**) to the individual in that situation (Wallston and Wallston, 1984). The equation relating social behaviour to behaviour is represented as follows:

$$\mathbf{BP} = f\,\mathbf{(E, RV)}$$

Of all the constructs, expectancy receives the most attention. The expectancy construct particularly researched is "internal verses external locus of control of reinforcement." This refers to the generalized expectancy (with regards to each element in the equation, it can be measured in general or specific terms, specific to expectancy) as to whether one's own behaviour or forces external to oneself control one's reinforcement.

Wallston and Wallston (1984) used this theory to explain health behaviour. They modified the equation as follows:

$$\mathbf{1.\ HB} = f\,\mathbf{(HLC \times HV)}$$

2. $HB = IHLC_T \times HV_T + PHLC - CHLC$

Where **HB** = health behaviour;
HLC = health locus of control;
HV = health value;
IHLC = internal health locus of control;
PHLC = powerful others health locus of control
CHLC = chance health locus of control

(*The subscript* (T) *indicate that the raw scores were converted to standardized T-scores to eliminate negative values before multiplying*).

Using these equations Wallston and Wallston (1984) generalized social learning theory to predict health behaviour. According to them, "a person is mostly to engage in a health behaviour given a belief in internal health locus of control and a high valuing of health." Low belief in a chance health locus of control could also facilitate health behaviour. If a person believes that health is strictly a matter of chance, there is no reason to take action. High belief in powerful others as a health locus of control will facilitate health behaviour recommended by health professionals. Wallston and Wallston (1984) also point out that the distinction between external beliefs **P** and **C** has proven useful in health research.

Some authors in recent years have advanced the understanding of health behaviours by modifying these traditional models (Hershey et al., 1975; Berki and Ashcraft, 1979) in order to make them relevant to their contexts. One such model is that postulated by Young (1980) which is a cross cultural adaptation of the HBM aimed at explaining treatment decision-making. There are four major elements to the model.

1 *Gravity* — which refers to the level of perceived severity of the illness held by the individual's reference group (this assumes that there exists, prior to the onset of illness, some group consensus about the relative and/ or absolute level of seriousness of various illnesses);

2 *Knowledge of a home remedy* — derived from a lay referral system (if such a remedy is unknown, or if it is tried and found to be ineffective, the individual is then likely to turn to the professional referral system).;

3 *Faith* — the level of belief in the efficacy of a different often supernatural treatment option (especially folk remedies); and

4 *Accessibility* — the cost and availability of health services (similar to the "perceived barriers" in the HBM and to "enabling factors" in Andersen's model).

The proliferation of models leads to confusion with regard to choosing a viable model for studying health behaviour. The presentation above of a few models highlights this problem. However, Cummings et al. (1980) after examining 14 models of this kind pointed out that although the models differ in their theoretical perspective, the types of health behaviours they explain and the set of terms they use to label the different dimensions and variables, the general classes of factors, at least superficially, appear to be quite similar. They have suggested "that the number of truly distinct concepts relevant to explaining health-related actions is considerably lower than the large number of variables currently employed". (p.123). These authors, using the actual model developers to act as judges, examined 109 variables extracted from the fourteen models and categorised them on the basis of their similarities. Six major categories emerged:

"1 *accessibility to health care*, such as the individual's ability to pay for health care and awareness of health services, and the availability of services;

2 *attitudes towards health*, such as, beliefs in the benefit of treatment and beliefs about the quality of medical care provided;

3 *threat of illness*, such as, the individual's perception of symptoms and beliefs about susceptibility to and the consequences of disease;

4 *knowledge about disease*;

5 *social interactions, social norms and social structure*, and,

6 *demographic characteristics* (social status, income and education)," (p.137).

This study contributes towards a more unified approach to understanding health behaviours and its integrative approach has greater merits for investigating health behaviours in various populations and socio-cultural settings.

2.4 CRITICAL ISSUES IN HEALTH BEHAVIOUR

2.4.1 PERSONAL AND DEMOGRAPHIC

Several studies have documented certain demographic patterns related to health behaviours. One such study (Christie and Lawrence, 1978) found that attitudes towards hospitalization was correlated negatively with age among men and positively with age among women.

Other researchers have noted gender differences in health behaviours. More men than women smoke although the rate of decline of smoking is more rapid among men than women (Fiore et al, 1989). Higher alcohol consumption has been reported in men, although more women have more multiple addiction in which alcohol is combined with prescription drugs (Koss and Woodruff, 1991). With regard to problems of eating, obesity and dieting the incidence of these disorders are more common among women than men.

Regarding the utilisation of medical care, it was found that women between the ages 17 and 44 make twice as many visits to a doctor than men (Verbrugge, 1985). Verbrugge points out that the mean number of visits made by women to a doctor is 30 percent higher than for men (ie. after controlling for visits related to childbirth) and that after the age of 45 years women's outpatient visits still exceed that of men by 10 percent to 20 percent. Although women seem to have more chronic illnesses and visit doctors more frequently, the rate of hospitalisation between the gender groups are not different. Women's average length of stay in hospitals are much shorter than that of men. It is generally accepted that women use more types of medications and to a greater extent than men do (Svarstad et al., 1987; Verbrugge, 1985).

Zadoroznyj and Svarstad (1990) have shown that together with gender, employment is also associated with lower incidence of drug use among men but not among women. In a study by Lave et al. (1979) it was found that low-income, unmarried males who had recently moved into a community were least likely to have a regular source of health care.

Women and married persons residing in a community for some time and who had higher incomes had a more stable source of health. Another study showed that even when economic barriers to health care are removed, poor people still do not use dental care to the same degree that richer people do. Luft, Hershey and Morrel (1976) observed that in a rural community the "health status" and the "regular source of care" were better predictors of the use of services than income or medical insurance. Wan (1976) showed that health status is a function of employment status in addition to the severity of disability, the need for assistance in mobility and psychological well-being. Working women tend to have a different set of health beliefs and practices than non-working women and this is considered an important factor responsible for lower morbidity in their children (Murabak et al., 1990).

Education has been found to influence the selection of services other than those of district clinics (Titkow, 1983). In the U.S.A. education has also been found to be positively correlated with the use of hospitals (Okafor, 1983) and the seeking of abortion at clinics (Li et.al., 1990)

According to McClain (1977) people who are acculturated (i.e.especially those who are younger, wealthier, and better educated) use western treatment facilities to a greater extent than those who are less acculturated.

2.4.2 HEALTH BELIEFS

The health beliefs that people have influence how they respond when they perceive themselves as ill, how they prevent illness, maintain good health, diagnose symptoms and treat bothersome and/or persistent conditions.They may treat themselves or consult family or friends. Clymer, Baum and Krats (1984) found that patients after evaluating their symptoms mostly treat themselves or seek help from medical professionals or alternatively consult folk or traditional healers. According to Mechanic (1983) and Christman and Kleinman (1983) medical practitioners are normally the last choice.

According to Mechanic (1976a) health care facilities are also affected by *inter alia* the dominant beliefs about illness, accessibility, financial means, the stigma associated with help-seeking and organisational barriers. Of these factors shared cultural beliefs and styles (i.e. culturally sanctioned way of doing things) are particularly important. In the following chapter cultural beliefs specific to African people will be discussed.

2.5 SOCIAL SUPPORT AND HEALTH

There is an abundance of research that demonstrates the positive effects of social support to health and health behaviour (Cohen and Syme, 1985). The absence of social support has been directly related to increase of psychological and psychiatric symptomatology (Henderson, et al., 1978, 1980; Kessler and McLeod, 1985) as well as physical illnesses (Gore, 1978; Sarason, et al., 1985; Wortman and Conway, 1985; Schaefer, Coyne and Lazarus, 1981; Östergren, et al., 1991). Social support is known to act as a buffer between stressful life events and health (Östergren, 1991; Turner, 1981; Billings and Moos, 1981) even in extreme stressful situations, such as, the violence in South Africa (Dawes, 1990).

Cohen and Syme (1985), in attempting to integrate the findings in this vast array of literature that includes multiple perspectives, definitions and outcomes, define social support as "the resources provided by other persons." (p.4). Social support incorporates several dimensions, which Tardy (1985) divides as follows: the *direction of support* (ie. it can be given or received), *disposition* (the availability vs. utilization of resources), d*escription of support versus evaluation of satisfaction* with support, *content* (what form the contact takes), and *network* (what social system/s provide the support). Social networks have been found to influence a variety of health behaviours, namely, the seeking of medical care, the influence of lay referrals and the utilisation of services influenced by family, relatives and friends.

Two views have been put forward on how social support operates to improve health. One view is that support acts as a *buffer* that protects the individual from the harmful effects of stress or stressful situations. (Cohen and Mckay, 1984; Dawes, 1990). According to this

view, support may intervene between the stressful event (or expectation of it) and the stress experience, by reducing or preventing a stress response, or by eliminating the stress experience by influencing responsible illness behaviours or physiological processes (Cohen and Syme, 1985).

The other view is the *direct effect* hypothesis that support enhances health and well-being regardless of the level of stress. It is believed that the perception that others are willing to help could result in increased overall positive feelings, enhanced self-esteem, stability and control over one's environment which in turn may influence susceptibility to illness by indirectly strengthening the immune system (Zimet et al., 1988).

It may be that both views have validity. While social support may be directly helpful in all circumstances, it may be particularly effective as a buffer during stressful times (Zimet et al., 1988).

2.6 SYMPTOMS AND SYMPTOM PERCEPTION

Leventhal (1986) points out that the importance of symptoms can be viewed from three perspectives: that of public health, medicine and lay people. Firstly, from the public health perspective, household surveys provide useful information on the incidence and prevalence of a variety of diseases which are necessary for the control and planning of public health. Secondly, in medicine, symptom reporting is often the initial contact with medical professionals that guides the hypothesis formation about underlying conditions, the ordering of further tests and the making of a diagnosis. Lastly, symptoms are of particular importance to the lay-person since it is an essential step in the process of seeking help for illness.

People experience symptoms of illness on a fairly regular basis (Bishop, 1984; Mechanic, 1978) although many of these symptoms are ignored and go untreated. In Bishop's study (1984), some "seemingly serious" symptoms went untreated. It would appear then that

the conceptualization of illness plays a critical role in determining a person's illness behaviour (Bishop and Converse, 1986). Matthews, et al., (1983) have shown that the interpretation given to symptoms influences both the urgency with which help is sought as well as sick-role behaviour itself. Illness representations have been found to play a crucial role in illness behaviour. Bishop and Converse (1986) in a study on how lay people come to identify a set of symptoms as indicating a particular disease, found "that information about physical symptoms is organised and processed according to pre-existing beliefs about the association between particular symptoms and diseases." (p. 95). Accordingly, these "disease prototypes" help individuals make sense of the changes they experience and what to do about them. These disease prototypes, however, may or may not be accurate and may not always result in optimal help-seeking.

On the other hand, symptoms are not always reliable indicators of disease. Reasons for such a view come from sex differences in reporting symptoms. Women on the average report more symptoms than men (Verbrugge, 1985). There is also a lack of clarity between psychological conditions and symptoms (somatoform disorders), symptoms as products of environmental conditioning and symptoms as indicators of mental, social and disease status (Leventhal, 1986). Levenstein (1990), is of the opinion that symptoms on their own have no 'objective reality' and that, therefore, a physician should understand his patient rather than interpret his or her symptoms.

2.7 LIFE EVENTS, STRESS AND ILLNESS

Stress has been linked to the development, exacerbation and maintenance of a number of health problems. Several studies have shown that there is a direct relation between stress and physical illness (Rahe and Lind, 1971; Holmes and Rahe, 1967; Feuerstein, Labbé and Kuczierczyk, 1987; Selye, 1956; Turton and Chalmers, 1990; Steptoe, 1991).
Several models have been postulated to explain the role of stress in the etiology, exacerbation and maintenance of physical illness. One of the most frequently cited is that of Selye (1956), who focused on neuro-endocrine aspects, and conceptualized stress as a

non-specific response adapted to protect the individual from any demands made on him or her. Further, that stress can result from both positive and negative responses. Levi's model (1972) suggests that any psycho-social change can act as a stressor and that this stimulus acts neuro-endocrinolgically in a predisposed way.

In Rahe and Arthur's model (1978), emphasis is placed on the significance of recent life changes or situations which are influenced by the individual's perceptive set. The perceptive set is influenced by the social supports and early life experiences. Included in this model is the use of psychological defenses which reduce physical arousal and as a result reduce susceptibility to illness. Figure 1 below presents an overall view of the conventional stress-vulnerability model (Steptoe, 1991).

Steptoe (1991) maintained that the psychobiological stress response (Stage II in Figure 1) is a loosely coupled system involving adjustments at the affective, cognitive and behavioural levels, together with associate changes in neuroendocrine, autonomic and immune function which have been challenged in modern research. Firstly, he challenges the notion of nonspecificity (Selye's 'nonspecific pattern of activation') because recent studies have shown that the pattern of neuroendocrine and autonomic responses varies according to the emotional demands. That is, it is not simply an intensity effect but a consequence of coping behaviours engaged in the situation. Secondly, it is difficult to apply the view that physiological stress responses are adapted to bolster the organism's biological defences which manifest as anti-inflammatory and immunosuppressive effects of glucocorticoids. It is suggested that several components of the activation profile may have a "regulatory rather than a direct resistance function." (p. 635). Thirdly, the view that peripheral physiological changes are secondary to central nervous system activation in the stress process is misleading since recent evidence suggests a bi-directional traffic between the two.

According to Steptoe (1991) there are two major issues with the models linking psychobiological stress responses with illness. Firstly, why do some people become ill when exposed to adverse circumstances and experiences while others do not ('intensity

issue'). Secondly, why do susceptible people who have similar life experiences develop different types of illness (variability issue). These individual differences in illness susceptibility is ascribed to biological predispositions (refer to Figure 1 - Stage III) such as genetic make-up, health status, nutritional state, physical fitness, and pre-existing pathology. Another possible explanation for some of the individual differences in the susceptibility of illness may be the result of specific patterns of psycho-biological responses to particular experiences.In addition to the psycho-physiological view, another position, which is often overlooked, through which psycho-biological responses may influence health is the cognitive-behavioural position. This view implies that cognitive, affective and behavioural components of the psychobiological response can influence health independently of any direct action of stress on the physiological system; that is, that psychosocial stressors influence health alterations in health-related behaviours and practices, such as, drinking alcohol, smoking, regular exercise, sexual behaviour or the use of seat belts. It would appear that the frequency of patterns are altered by psychosocial stress rather than influencing them. Other cognitive behavioural processes include attention to bodily symptoms, ranging from extreme preoccupation to avoidance or denial influence help-seeking behaviour.

Emotionally expressive behaviours may also account for associations between psychobiological stress and illness. For example, in “crying-induced asthma” bronchospasm is precipitated by crying through a nonspecific pathophysiological mechanism such as bronchial hyperactivity rather than a specific psychophysiological cause. Studies of crying induced asthma show that it is triggered off during stress-related episodes of emotional disturbance and is maintained by parental responses. Also, adverse life experiences may affect illness progression by disrupting adherence to medical regimens or advice. The point here is that cognitive-behavioural elements of the psychobiological stress responses can influence the health status irrespective of psychophysiological connections. Hence, Steptoe (1991) suggests an elaborate model detailing the cognitive-behavioural and psychophysiological processes that mediate stress-illness relationships (see Figure 2).

What is clear in the preceding discussion is that stress influences health in a complex way. More specific hypotheses related to various cognitive-behavioural and physiological processes are needed in order to fully understand the actual process.

CHAPTER 3

HEALTH IN SOUTH AFRICA

The health system of South Africa is unique in many respects because its development and structure has been strongly influenced by a unique political ideology of racial separation. Although this ideology (the apartheid system) has undergone radical changes in the past two years, the problems and effects of the past will continue to be experienced for a very long time. The racial segregation of the health system has led to discrimination and fragmentation in health services as well as large disparities in health services between the different population groups.

The relationship between apartheid and health, both direct and indirect, is multi-levelled and its effects are felt in several ways:

1 the state-provided health services for black people are grossly inadequate (De Beer, 1984; Reddy, 1990; Zwarenstein and Bradshaw, 1989; Chetty, 1990). This deficiency has, obviously, a negative effect on health care;

2 the inequalities and discriminations have led to severe social problems, such as, poverty, unemployment, over-crowding, poor education and inadequate housing which naturally adversely affect the health status of these communities (De Beer, 1984);

3 dietary deficiencies affect health status (De Beer, 1984);

4 disruptions in family life through migrant labour and influx control have increased the vulnerability to illness and diseases (Uyanga, 1983; Maforah, 1988);

5 the stress of living under an oppressive system (Dawes, 1990) also directly affects the health status of both individuals and whole communities;

6 the restriction and distortion of normal personality development (Manganyi, 1977); and

7 the promotion and maintaining of negative health behaviour and help-seeking behaviour.

This section will focus on those factors that contribute to negative health behaviours. One factor that has received much attention is the gross lack of adequate health services and health facilities for black South Africans. The term "health facility" refers not only to the physical structure from which health care is delivered but also to the quantity, range and quality of care provided by the facility. The health facilities in South Africa are biased not only in favour of white people but also the affluent and the urban. During the period 1983-84, the available data for the hospitals in the Transvaal show that there were 6, 27 beds per 1000 population for whites and 3,14 beds per 1000 for blacks (Buch, 1987). The lack of services and facilities undoubtedly restricted appropriate health action on the part of these people. Moreover, these facilities are always overcrowded and as a result there is a tendency to delay seeking help because of the inconvenience of spending a considerable amount of time in order to see a doctor. Patients often spend a whole day in order to be seen by the doctor for a few moments. It is not unusual for patients living in rural areas to leave home and spend a week in transit, sleeping over at different hospitals *en route* in order to obtain transport to the main teaching hospital in the city, only to be seen by a doctor for five to ten minutes (Dr. Hunter, personal communication, May 1992). Within such a context medical help-seeking behaviour will be determined almost solely by the severity of the illness. There is very little motivation to visit a doctor for a check-up or to screen for illness or diseases. It is to be expected that lay or folk medicine will be substituted in these cases.

In addition, health care concerns itself mainly with curative and hospital services. In certain communities such as squatter or informal settlements, health facilities are virtually non-existent. Buch (1987) suggests that one of the reasons for this absence of facilities not

becoming a serious problem for these settlers is that “such communities are not yet in a position to judge their health services in the same astute manner in which they judge their education and housing.” (p. 52).

Health service location also plays an important role in terms of utilization of services and help-seeking. The best health facilities available have been developed in close proximity to the city centre. The irony of the situation is that not only is it difficult for rural people to reach these facilities but it is also not immediately accessible to those living in urban areas as well. The reason for this is that due to the Group Areas Act, the urban black is settled away from the city centre. Blacks are thus faced with problems, such as, accessibility of hospitals and clinics, transport costs and their inability, especially if they are old, to get someone to accompany them on their long trip to the city. These factors obviously negatively influence health behaviour.

Another factor that negatively influences health behaviour is the political climate in the country. In the process of lobbying for a democratic government and better facilities, the ideologies and strategies employed by various organisations have to some degree influenced and affected the health behaviour of the African people. “Stay aways” in June 1991 and June 1992 showed significant decrease in visits by patients to hospitals providing services primarily to blacks (e.g. King Edward VIII) and at black private practices as well. The protests and boycotts by nurses in 1991 and the strikes called by the National Education Health and Allied Workers Union (NEHAWU) in June 1992 resulted in severe disruption of hospital services, creating in many instances health crises. Hospitals were forced to reduce admissions and provide only emergency services. While these protests and boycotts may have certain national political implications, its impact on health behaviour as well as health care on the immediate, short term and long term is not fully considered, assessed or comprehended. Not only is the health of individuals jeopardized but theses experiences have the potential of becoming integrated as part of their health beliefs.

Another closely related factor that has a negative influence on health behaviour is the response to health education programs and the use or lack of use of present services by some individuals as a result of their political beliefs and affiliations. State education programs and services are often viewed with suspicion; For example, the rumour doing its rounds in some black communities is that AIDS had been introduced into South Africa by the State to destroy the African race. Such views obviously contribute to poor motivation in individuals to attend state hospitals and affects their attitude and behaviour. Another concern is that sometimes state hospitals become associated with pro-government groups. It is worth noting that in Natal there are strong affiliations among blacks to both the African National Congress (ANC) and the Inkatha Freedom Party (IFP). The latter is often regarded as pro-government. (Much of the violence in Natal has been ascribed by most political analysts as emanating from clashes between theses two groups. There is a belief in some black circles that the government has perpetuated the violence). For example, it is quite common for psychotic patients, who are admitted to the psychiatric ward at state hospitals, to develop delusions of being in danger from other political groups because of the belief that the hospital is in sympathy with that particular group, or they may develop a delusion that they are going to be “brain washed” by the government if they are hospitalised. In some cases medical facilities may be underutilised partly because of the political allegiance of people in its environment to anti-government groups. A case in point is the Prince Mshiyeni Memorial Hospital in Umlazi. This distrust of medical care systems has been noted amongst minority groups, such as, Jews, Puerto Ricans and Blacks in North America as well (Geertsen, et al. 1975; Lendt, 1960).

Further, a person’s belief that better treatment is provided at only certain hospitals may also influence equitable use of health services. For example, patients often insist on coming to King Edward VIII Hospital and not attend a facility closer to them because they believe that superior treatment is provided here.

3.1 CULTURAL INFLUENCES ON HEALTH

It is well known that cultural determinants play an important part in maintaining a sense of good health. Cultural values, norms and expectations influence and shape beliefs, lifestyles, family interactions, roles, social organisation and institutions (Gochman, 1988). Cultural influences affect not only perspectives on health, illness and disease (e.g. patterns of diseases) but also a variety of health related behaviours, such as, beliefs that underlie the utilization of services (Berkanovic and Reeder, 1974), seeking of medical care (Berkanovic and Telesky, 1985) responses to pain, responses to symptoms, (Guttmucher and Elinson, 1971; Klienman and Sung, 1979), the sick-role (Davis, 1984) and the use of traditional healers (Uyanga, 1983; Freeman and Motsei, 1992). Suchman (1965a) emphasized the place of cultural patterning on social organization and health services. The "total culture's beliefs and behaviours related to health, and its sanctioning and organizing of healing practices are referred to as a 'health culture' " (Gochman, 1988, p. 243).

For black South Africans, alongside the western medical system exists an old traditional system of healing and health care. Their cultural and social beliefs have been shown to contribute to the way they conceptualize illness and disease and use health care facilities. Traditionally, they view illness in terms of natural, moral and magical aetiologies. See Figure 3 below (Wessels, 1985a, 1985b).

Ngubane (1977), in discussing models of illness among Zulus, notes the distinction between illnesses that are universal and treatable biomedically (*umkhuhlane*) and those which may require ritualised and indigenous cures (*ukufa Kwabantu* - disease of the African people). *Umkhuhlane*, according to Ngubane, refers mainly to those illnesses that "just happen." They include illnesses that range from common colds to serious epidemics such as smallpox. They are seen as part of the process of ageing resulting in the dysfunction of individual body organs and also include organ malfunction that may lead to other illnesses, such as, excessive bile accumulation (*inyongo*) which is believed to cause headaches, nausea and general debility. Included in this category are diseases associated with development in infants; for instance, measles (*masisi*), mumps (*uzagiga*) and discomfort during teething. Also included in this category are illnesses associated with seasonal changes, such as, diarrhoea (*uhudo*) and hay fever (*isithimulane)* which occur mainly in the summer. *Umkhuhlane* may also refer to diseases that are believed to be inherited. These include epilepsy (is*ithuthwane*), chronic chest pain, asthma or chronic bronchitis (*ufuba*), skin infections (*umzimba omubi*) as well as mental retardation and certain mental illnesses (*ufuzo)*.

Medicines that are used to treat the *umkhuhlane* category of illnesses are believed to be very potent and therefore there is no need for their administration to be accompanied by rituals. People are ready to experiment and try any new medicine to treat these illnesses. Hence western medicines for this class of illnesses are readily accepted.

The other category (*ukufa kwabantu*) includes illnesses whose aetiology and meaning is based on African culture. According to Ngubane (1977), *ukufa kwabantu* is used to indicate that "not only the disease, or their symptoms, are associated with African peoples only, but that their interpretation is bound up with African ways of viewing health and disease." (p. 24). It is with this category that mental health workers, such as clinical

[1] Ngubane's *Body and Mind in Zulu Medicine* represents the most comprehensive primary source on Health and Disease in the Nyuswa- Zulu thought and practice and is very frequently referenced by most researchers in cross-cultural studies. This source is extensively used in this study. This study has also greatly benefited from this source.

psychologist and psychiatrist, are directly involved. (It is therefore given fuller treatment in 3.2).

It is important to note that although this distinction between “African” and “non-African” illnesses is often referred to in the available literature (Cheetam & Cheetam, 1976; Edwards et al.1983; Le Roux, 1973; Wessels, 1984a), it is not without some lack of clarity. For instance, Mills (1983; 1985) has found that some illnesses such as tuberculosis are viewed by some African communities purely biomedically whereas in other contexts they are viewed in the traditional way.

3.2 AETIOLOGY OF ILLNESS IN THE AFRICAN WORLD VIEW

3.2.1 Environmental Imbalance

According to Ngubane (1977) concepts of ecology are central to the Zulu idea of health and explanations of ill-health may often lie in interpretations of environmental imbalances. The belief is that there is a special relationship between a person and his environment, and that plant and animal life affect the environment as well. Because different places have different types of plants and animals, environments and atmospheric conditions vary between regions. People are acclimatized to where they live and moving to a new region may lead to illness until they have adapted to the new place. It is also believed that when moving, both animals and people leave something of themselves behind and also absorb something from the atmosphere into which they move. This “something” that is left behind is what is used by dogs when tracking and is known as *umkhondo* (track). These “foreign elements” are thus introduced into a region by people in their travels or wild animals and birds that travel long distances. The *umkhondo* may be visible or invisible; harmless or harmful. Harmful tracks are referred to as *emibi* (bad). A person may contact a disease by stepping over a dangerous track or breathing it in. The word *umequ* is used to refer to all diseases contracted by stepping over a dangerous track, regardless of the symptoms. The environment may not only be polluted by tracks but by

things discarded during the traditional healing of someone, as well as by noxious substances placed by sorcerers. In this way the environment has the potential to become dangerous. In order to develop and maintain resistance to evil or illnesses an equilibrium must be established between a person and his or her environment as well as between individuals in a society. This resistance is needed because it is also believed that a person may be overpowered by the presence of another person and become ill. The balance with the environment is achieved by the use of "strengthening medicines". Ideally, strengthening should occur at least once a year in spring before the thunderstorms because these strengthening treatments protect against lightning as well.

Ecological factors are considered the primary cause of a variety of illness. For example, babies that cry continuously, appear fearful or show general distress are said to suffer from *inyamazana* (problems resulting from certain wild animal tracks). Green stool resulting from diarrhoea and a white-coated tongue are believed to be the result of contamination from lightening fumes. Miscarriages, still-births and infant mortality is also associated with pollutants in the environment which are contracted by pregnant or nursing mothers who then infect their babies. In adults, symptoms ranging from general infirmity of the body to evil possession are associated with dangers in the environment.

3.2.2 Sorcery and Illness

Illnesses may also result from sorcery (*ubuthakathi*). There are three types of sorcerers: The first, is the "night sorcerer" who is believed to be evil. They are always men and they harm others for no apparent reason. A night sorcerer uses evil medicines (potions) and is believed to have supernatural powers, such as resurrecting corpses but, he cannot fly, change shape, become invisible or perform acts associated with wizards. His aim, according to Ngubane (1977), is to make the environment dangerous or put people out of balance with the environment. He achieves this by placing harmful medicines in the environment so that people may step over it and contract *umeqo*. The second type is referred to as the "day sorcerer" who acts out rivalry and competition. These sorcerers

may be men or women; the latter are in the majority. Their method of harming people is referred to as *ukudlisa*, which is the adding of noxious substances, including western poisons, to the victim's food. They may use supplementary techniques, such as, placing harmful substances in the victims path or steal portions of their victims sacrificial animal in order to nullify the sacrifice or reverse its purpose. The third type is the “lineage sorcerer” (*uzalo*). The *uzalo* are members (only men) of a common lineage who share certain ritual and social obligations towards each other. They are not supposed to practise night or day sorcery against each other because this will anger the ancestors. However, a man can persuade the ancestor to favour him and abandon one or more of the other members of the lineage. This is achieved by the use of “black medicines” (*ukuphehla amanz'amnyama)* in the treatment of disease.

3.2.3 Ancestors and Illness

Ancestors (Ngubane, 1977) are primarily concerned with the welfare of their descendants. When things go well, people believe that they have the support of the ancestors (*Abaphansi banathi*) and when misfortune befalls them, the ancestors are believed to be “facing away from them” (*Abaphansi basifulathele*). There are two classes of ancestors: those who can punish or protect and reward, such as, a man's mother, father, paternal grandparent as well as paternal uncles; and those three generation removed, who do not punish or reward but are allowed as guests of the former ancestral group. The ancestors are believed to live underneath the earth. They frequent the hut of the most senior women of the group (*indlu enkulu*) and the byre. The ancestors are appeased through sacrifices. The following is the list of the sacrifices that are performed:

1 *Imbeleko* - a sacrifice to place a baby under the protection of ancestors;
2 *Ukubuyisa* - a sacrifice to integrate the deceased with the rest of the body of ancestral spirits;
3 *Ukubonga* - a sacrifice for good things in life, eg. winning money and obtaining a good job;

4 *Ukucela izinhlanhla* - a sacrifice to seek blessings from the ancestors before undertaking any major or risky task, eg. going to a major city to seek employment;

5 *Ukushweleza* - a sacrifice to appease the ancestors if there is evidence that they have been annoyed;.

6 *Ukuthetha* - a sacrifice to "scold" the ancestors if misfortune continues in spite of their attempt to appease them; and

7 *Ukukhomba inxiwa* - a sacrifice when moving house to show the ancestors the new home (Nugubane, 1977).

Without the protection of ancestors the people become vulnerable to misfortune as well as diseases. Ancestors are most often annoyed by quarrelling in a home, lack of peace or the non-fulfilment of marital duties. Examples of illnesses and misfortunes resulting from the displeasure of the ancestors are infertility, miscarriages, delayed conception, the sudden illness of children, strokes, paralyses, sleeplessness and tension or strife in the household.

3.2.4 *Umnyama* and Illness

Another important concept in the African view of illness is *umnyama* (Ngubane, 1977). It can be translated "pollution" which is conceptualized as "a mystical force which diminishes resistance to disease, and creates conditions of bad luck, misfortune (*amashwa*), 'disagreeableness' and 'repulsiveness' (*isidina*) whereby people around the patient take a dislike to him without provocation" (p.78). *Umnyama* in its worst form is contagious.

The behavioural pattern of those in a state of *umnyama* is referred to as *ukuzila* and is characterized by withdrawal, asocial behaviour and abstinence from pleasurable activity; Those inflicted become passive, softly spoken and lethargic; they lose their appetites or eat small quantities of poor quality food and dress sloppily. Post-partum women are regarded as polluted (*umdlezane*) and can pollute and cause ill-health to their children and family. The virility of men is affected if they eat food cooked by her or share eating utensils with her. She is to be confined because even contact with cattle will stop their production of milk. She may not even go into the fields lest the crops wither. Other occasions of pollution are menstruation, sexual intercourse (men and women are considered polluted the day following sexual intercourse), premarital sex (i.e. the females are considered polluted) and fighting.

Pollution is also associated with death. It is believed that pollution emanates from the corpse and those that handle corpses and those associated with death are polluted. This pollution is contagious. Certain deaths are regarded as more intensely polluting than others. These are deaths through car accidents, drowning, being struck by lightning, fighting, murder and, those who die of incurable diseases, epilepsy and chronic chest diseases. Their bodies are never brought to the home but are buried outside and weeping is restrained. With regard to murder, in addition to the pollution of the death, the murderer is especially polluted.

It is interesting in the resolution of this pollution through ritual that psychological aspects of important life events are addressed and dealt with. The traditional rituals and cultus is endemic to the process of coping with the stresses, anxieties and emotional instability that accompany important events in both the life of individuals and communities. Clinical psychologists probably obtain their most important clues to understanding the psyche of their African patients to the extent the attitudes informing these ritual resolutions are understood. As Ngubane (1977) points out "emotional stresses endured during both birth and death—the two mainsprings of pollution—are prevented from initiating neuroses by the diversion of focus from unpleasant experiences to a complexity of ritual behaviour. The mental stresses and strains experienced during the major life crises are seen as a possible cause of permanent damage to some people's mental balance, and this is expressed as an outcome of flouting the behaviour pattern." (p.82). We may add that even where there is no danger of mental imbalance, the traditional perception of the all-pervading possibility that pollution affects general attitudes to psychological well-being and sickness or health behaviour.

3.3 ILLNESS, SICK-ROLE AND HELP-SEEKING BEHAVIOUR

According to Ngubane (1977), in Zulu society, when people feel sick they report this to those around them. They observe the symptoms and try and associate it with a disease, at first to decide whether it is a minor ailment which could be treated at home or a serious illness which needs the attention of an expert. The severity of the illness is assessed by the behaviour of the person. If a person is sick but continues working he or she is sick "but goes about with it" (*uhamba nako*). If he or she lies down (*ulele phansi*) the illness is considered serious and those around him or her become concerned.

If minor ailments persist or worsen in spite of home remedies, an outside opinion is sought by taking the person to either a doctor or a traditional healer. It would appear that no particular help-seeking behaviour pattern is followed here. The decision to contact a doctor or healer is influenced by factors such as the seriousness of the illness, availability

of health services, financial implications and the person responsible for the decision. The head of the home has to make the decision whether to see a traditional healer, doctor or home remedies. If the head of the household is absent another may make the decision but no major decision such as hospitalisation can be made without consulting the head of the home. It is important to note here that since the head is usually away from home (e.g. he may be a migrant labourer in another city) the delay in consultation contributes to delays in health action.

Support is usually provided by the immediate family who nurse and give the patient attention day and night if required. Msengi and Daynes (1981) reported that the management of illness of Africans in the Transkei was primarily done by relatives and then neighbours. Doctors' orders are strictly adhered to and if necessary outside visitors may not be allowed to visit the patient. Family members in a state of *umnyama* may not come into the house were the patient is.

Ngubane (1977) refers to certain typical attitudes and beliefs that are implicit in this world-view. For instance, malingering is treated with great contempt and no self-respecting person would consider it. With regards to sick-role, a person is encouraged to get up as soon as he or she can because it is believed that lying down (unless absolutely necessary) weakens the body. Getting up and moving around is believed to speed up recovery. African society encourages stoicism. Pain is expected to be tolerated without complaining. For example, a woman in labour who does not utter a sound is congratulated and complimented whereas those that cry disgrace their family. In addition, a sick person is encouraged to eat to strengthen the body and promote a speedy recovery. Soft foods and liquids are prepared for those with poor appetites. In the case of infants with loss of appetite, they are "forced fed" by the process *ukaxaka*, which is the holding of the nose of children so that they breathe through their mouth which forces the mouth open so that they can be fed.

3.4 TRADITIONAL TREATMENTS

Traditional treatment, according to Ngubane (1977), is provided by the *inyanga* (traditional doctor) and *isangoma* (diviner). The *inyanga* , usually a man, must first serve an apprenticeship for a period not less than a year. Sometimes the skill is passed from a father to a son who shows an interest in traditional medicine. The *isangoma*, usually a woman, is required to have a comprehensive knowledge of traditional medicine. A person is "called" or chosen to be a *isangoma* by the ancestors who bestow special powers on the individual. In addition to the *inyanga* and the *isangoma* there are those who prepare medicines for a particular type of illness or possess knowledge on how to deal with particular health related situations — they are known as the *inyanga* of a particular disease or condition, for example, *inyanga yomhlabelo* — the doctor who handles fractured bones. These are the equivalents of specialist healers.

Traditional healers play a central role in African rural communities but their influence is still fairly extensive among industrialised and urban communities as well (Wessels, 1984b).Traditional healers according to Cheetam and Griffiths (1980) and Wessels (1983; 1985c) are highly respected individuals in their communities and are usually consulted first by all Africans except those who have become highly westernized. (Wessels, 1985c). De Beer (1980) reported that 60 percent of consults to traditional healers were for treatment of a disease. Watts (1980) found that there is a tendency to under-report the use of traditional healers which means that De Beer's estimate is lower than it may in fact be.

With the rise and development of the indigenous churches, a new type of healer has emerged - the "prophets" or "faith healers"(Wessels, 1987a, 1987b). They use both traditional methods as well as "Christian approaches" in their treatments. The main differences between "faith healers" and "traditional healers" are that these prophets are Christians who are church leaders; They pray and use holy water, and the sacraments of baptism, the eucharist and unction, whereas diviners use traditional herbs, bones and medicines (Wessels, 1987b; 1989). The prophets maybe less knowledgeable of the sickness specific to African culture than traditional healers. In addition to healing those who have suffered misfortune, faith healers minister to those who suffer from

schizophrenia, epilepsy, mental retardation, and inherited disorders. According to Wessels (1987b), faith healers play a very useful role in the African community in handling day to day problems of living. He maintains that because of their efficacy in assisting people in need they should be given recognition and trained as village mental health workers. The fact that the African Independent Churches are the fastest growing religious movement in Africa (there are over 3000 different churches in South Africa alone) indicates the extent of their success in African societies (Oosthuizen, 1986; Sundkler, 1976).

In addition to rituals such as dancing, calling up the spirits of the ancestors and bone throwing (Ngubane, 1977; Wessels, 1985c) medicines are also administered. These are usually made from leaves, bark, roots stems, bulbs, fruit and/or seed that are either fresh or dried and sometimes powdered. These medicines are often boiled and taken orally. They are sometimes used as purgatives, usually to reduce excess gall which is believed to be the cause of stomach disorders. Purgatives are also taken in the form of an enema. It is believed that the purgatives clean out the cause of the illness. This practice, however, has often contributed to irreparable physical damage and even death. In the hospitals it is a very common experience to find children and adult seriously ill as a result of the use of purgatives. Various lethal substances have been found to be used as enemas; the most common are Jeyes Fluid, detergents, battery acid and potassium permanganate that are believed to have cleaning properties. Some of the herbs that are used (e.g. *impela*) are extremely poisonous. Sometimes herbs are believed to make individuals omnipotent. For example, *intelezi*, which is given to individuals to murder others but these individuals will not come to danger or feel remorse over their actions.

The herbal medicines are divided into those that have healing properties and those that are used in rituals and have symbolic meaning. This latter group is usually used as prophylactics or to remove the cause of illness rather than to cure organic symptoms. Faith healers use prayer and holy water (*iziwasho)* for this purpose.

Based on actual cases seen by the author.

Based on actual cases seen by the author.

CHAPTER 4

METHOD

4.1 SUBJECTS

The total sample in this study (N=892) consisted of 3 groups of urban Africans who were 20 years and older. Group 1 (N=376) comprised first time attenders to the medical outpatients department at the King Edward VIII Hospital in Durban, South Africa. The ages ranged from 20 to 74 years with a mean of 34,88 years. Group 2 (N=362) and Group 3 (N=154) were sample groups drawn from the Umlazi Township and the Kwa Mashu Township respectively (see figures 4 and 5). The number of subjects selected for each of the Groups 1, 2 and 3 were drawn *pro rata* to the total population of the hospital out-patients, Umlazi and Kwa Mashu townships, respectively. Throughout the study the groups will be referred to and identified as follows: Group 1 will be referred to as the Hospital Group, Group 2 as the Umlazi Group and Group 3 as the Kwa Mashu Group.

TABLE I
DISTRIBUTION OF SAMPLE BY SEX

Group	Male (%)	Female (%)	Total
Hospital	**164 (43.62)**	**212 (56.38)**	**376**
Umlazi	**160 (44.20)**	**202 (55.80)**	**362**
Kwa Mashu	**64 (41.56)**	**90 (58.44)**	**154**
Total	**387 (43.50)**	**498 (56.50)**	**892**

4.1.1 General Hospital Group

The King Edward VIII Hospital, where the hospital sample was obtained, was officially opened in December 1936. Originally, its purpose was to provide general medical care for Africans and Indians patients who were at that time inadequately catered for in the existing provincial hospitals (Dyer et al., 1986). Dyer et al. (1986) point out that the hospital was beset with financial problems from its inception. The lack of funds was partially alleviated by second-hand equipment from Addington Hospital, Durban and the initiative of the nurses who made mattresses from the grass growing in the hospital grounds. The major problem was the shortage of beds. The problem of the shortage of funds and beds persists today in spite of the gradual but significant improvements made over the years. The hospital was extended as more ground adjacent to the hospital was acquired. Another extension was the acquisition of the World War II Imperial Forces transit camp at Clairwood, Durban, which was then developed into the present 1400-bed Clairwood Hospital. Further facilities were developed away from the hospital, such as the Beatrice Clinic in the city centre which is still presently operative. With the inception of the Medical School in 1951, major expansion of the hospital was undertaken (Dyer et al., 1986). Today, King Edward VIII Hospital is one of the major training hospitals in the country.

The medical outpatients department at the King Edward VIII Hospital annually attends to over 1 million patients. Approximately 1 500 new patients are seen each week. A representative, stratified sample of first time attenders was selected. A proportion of the sample was drawn on each day of the week at the outpatients because of the variation of the number of new patients attending each day of the week. The formula used to obtain the sample was:

[2] The choice of sampling techniques, statistical methods and analysis employed in this study were done in consultation with and under the supervision of two statisticians of the Medical Research Council (MRC).

$$N\frac{1}{N}x376 = N_{day}$$

where: N1 = No. of patients per N_{day}
(average over 4 consecutive weeks)
N = No. of patients per week
(average over 4 consecutive weeks)
376 = total group sample
N_{day} = day of the week

4.1.1 Community Groups

The community samples were taken from the two largest African townships closest to Durban namely, Umlazi and Kwa Mashu. The Umlazi Township which is located to the south of Durban with a population of 306 490 (population census, 1991 - provided by the Central Statistical Services, Durban) and the Kwa Mashu Township is situated north of Durban with a population of 156 621 (population census, 1991 - provided by the Central Statistical Services, Durban).

A representative, random sample was used. With the aid of site plans all dwellings were counted and assigned a number. A computer was used to generate random numbers which were used to select the actual homes to be visited by the interviewers. A list of 'spare' homes was also generated in the advent of alternative numbers being required.

[3] This figure represents the last official census of the township. However, this figure does not take into account the large number of squatters in the area.

The urban township samples were used as a control group both against which the hospital clinic group was compared, and in order to validate some of the questionnaires that were used in the study.

4.2 METHOD OF DATA COLLECTION

The HIB (Appendix A) in the language of the participants, was administered by trained black interviewers. The interviewers employed for this study had at least a matric qualification and were fluent in English and Zulu. They were personally trained by the author and after demonstrating sufficient expertise were accepted for the project. They were asked to adhere strictly to the instructions and the terms defined in order to reduce the level of bias. The answers to the open-ended questions were taken verbatim in Zulu and subsequently translated verbatim into English. If the question was not properly understood it was explained again in an open-ended, non-suggestive way and the answer was once more recorded verbatim.There were several reasons for the use of open-ended questions: to ascertain popular and folk ideas, attitudes, values and beliefs; to identify the predominant factors of concern and to avoid the possibility of suggestion in the answers. This approach is considered an acceptable way of obtaining information in cross-cultural settings (Schlebusch et al., 1990).

4.2.1 Hospital Group

The interviewer selected every 10th new patient waiting to be seen by the medical officer at the medical outpatients department. Table II below shows how the sample was obtained so that it would be representative of all the patients seen at the hospital. The final number per day, included in the hospital sample, was based on an average taken over three weeks.

TABLE II
SAMPLE SELECTION FOR HOSPITAL GROUP

Wk	Mon	Tues	Wed	Thurs	Fri	Sat	T
1	310	300	269	242	240	64	1 425
2	297	279	261	208	207	45	1 297
3	280	271	206	214	173	22	1 166
T	l 887	850	736	664	620	131	3 888
Av	295.67	283.33	245.33	221.33	206.67	43.67	1 296
Sm	79.84	76.51	66.26	59.78	55.83	11.80	

T = total; Av = average and Sm = sample

Interviewers introduced themselves, explained to the patient what the study was all about and requested their participation. They were told that their participation was voluntary and that their refusal to participate would not prejudice them in anyway. If the patient decided to participate, the interviewer assisted the patient complete the HIB.

After completion, the interviewer thanked the subject for their cooperation and the time they had volunteered.

4.2.2 Community Group

The interviewers equipped with a site plan of the area with the selected dwellings marked, visited the pre-determined addresses during the evenings and on weekends in order to ensure that all the members of the family were at home. They introduced themselves,

explained the purpose of the study and requested their participation. When permission to conduct the study was obtained, the interviewer allocated a number (printed on a disc) to each member of the household, even those unavailable at the time. The discs were thrown into a packet and one was randomly selected. The individual represented by the selected disc was asked to complete the HIB with the help of the interviewer. (If the person selected was absent, the interviewer returned by appointment to complete the HIB).

On completion of the HIB, the interviewer thanked the subject and other members of the family for their cooperation and the time they had volunteered.

The interviewers went through the list of pre-selected homes in exactly the same manner. If permission to conduct the interview was refused or a particular home could not be visited, the interviewer selected one of the homes from the spare list instead. The completed HIB was returned to the writer for analysis.

4.3 MATERIALS

The HIB comprised of the following questionnaires and inventories which were used to elicit information:

1. Health and Illness Questionnaire (HIQ)
2. Health Belief Questionnaire (HBQ)
3. Social Support Questionnaire (SSQ)
4. Hopkin's Symptom Checklist (HSCL) - (modified)
5. Life Experience Survey (LES) - (modified)

4.3.1 Health and Illness Questionnaire (HIQ)

This questionnaire was designed by the writer to elicit *inter alia* information on health and illness (see Appendix A, pp 1-6). The questionnaire is divided into several sub-sections.

Section 1.1-7 (p. 1) was used to collect biographical information such as age, sex, ethnic group, educational level, district, the number of years of residence in an urban area and nature of employment or working skills.

Section 2.1-5 (p.1) was completed by the hospital group only. This section assessed factors such as cost of transport, time taken to travel to the hospital, availability of sick leave by patients was pertinent, therefore, only to the hospital group.

Section 3.1-8 (p. 2) was completed by the hospital group only because it elicited information that dealt with factors associated with hospital attendance. These were factors that precipitated the patients attendance at the hospital, the person's understanding of these precipitating factors, the choice of hospital and the nature of the disclosure to others about his or her illness.

Section 4.1-3 (p.3) was completed by the community group only because these questions assessed the choice of services in the community.

Section 5.1-5 (pp. 3-4) looked at the use of medical and supplementary services and medication, and was completed by all the groups.

Section 6.1-5 (pp.4-5) elicited information on religious and cultural beliefs. These included religious affiliations; consultation with traditional healers, faith healers and herbalists; cost of services provided by traditional healers and the use of prayer. All groups completed this sub-section of the questionnaire.

Section 7.1-5 (pp.5-6) assessed health and illness beliefs. Subjects were required to explain what they felt concepts such as 'ill', 'sick', 'well' meant. They were required to list what

they thought made people sick , what health actions were taken and/ or what help seeking occurred.

4.3.2 Health Belief Questionnaire (HBQ)

This is a 31 item questionnaire (see Appendix A, p. 7) designed for the purposes of this study to ascertain health and illness beliefs. As discussed already in the previous chapters, the health and illness beliefs are not only strongly coloured by the traditional world-view but that the African view of illness is unique in many respects. Further, the groups being assessed are acculturating and are adopting western beliefs as well. None of the existing scales on health and illness beliefs were found to be suitable because they either did not take into account the African concept of health and illness or were standardised for western populations. In addition, they did not assess these variables at a level suitable for the purpose of this study. Further, some scales were either too general for our purpose or were specifically constructed to measure mental health. These include scales such as, the Health Locus of Control Scale (Wallston, Wallston et al.,1976) or the Multidimensional Health Locus of Control Scale (Wallston and Wallston, 1981) and Rotter's Internal-External Locus of Control Scale (Rotter, 1966).

The complex system of health and illness beliefs of this community, therefore, necessitated the development of an appropriate questionnaire. The questionnaire had to have items that were relevant for this culture and had to be broad enough to measure a variety of health beliefs to take into account the acculturation process at work in this community.

The HBQ requires the respondents to rate on a four point Likert scale whether they agree, sometimes agree, disagree or were ‘not sure’ about the statement presented.

4.3.2.1 Construction of Questionnaire

Based on a review of literature on African beliefs, the suggestions of six mental health professionals working in a cross-cultural setting and who deal primarily with African patients and the personal experience of the writer, 38 items were selected. The face and content validity of the questionnaire was established by asking a panel of experts in the area of cross-cultural issues to check the items. The panel of experts were made up of three clinical psychologists and two psychiatrists who made recommendations to improve the selection of questions and these suggestions were incorporated in the scale.

4.3.3 Social Support Questionnaire (SSQ)

A social support measure was included in the HIB because of the view that social support acts as a buffer against disease and are, therefore, necessary for the individual to cope with life changes and adverse events.The SSQ is a 15 item questionnaire (see Appendix A, p. 8) designed by the writer to measure primarily the qualitative and quantitative aspects of a person's network of relationships that help him or her in adverse circumstances. A review of several social support questionnaires showed that they were inappropriate as a measurement in the context of African culture, a point made also by McFarlane author of 'The Social Relationship Scale' (personal communication, 10 September, 1990). The variation in the standards of social adjustment from one culture to another is regarded as a major problem in the measurement of social support (Weissman, 1975).

The social network among black South Africans is unique in many ways as the usual social supports are not available. African family units have steadily been broken up. Maforah (1988) points out that the disintegration of the African family has been influenced *inter alia* by European contact with Africa which disrupted family life; new economic systems; political exploitation brought about by forced labour, racial segregation and alienation from the land. In our present context, fathers and mothers as well are forced to live away

from their families in order to find work or further their studies. Laws governing black re-settlement (e.g. the Native Land Acts of 1913 and 1936, the homelands policy and the Group Areas Act) have all contributed to the erosion of black families. Their effects last long after they have been removed from the statute books.

In developing this questionnaire I was guided mainly by the Sarason's et al. (1985) Social Support Questionnaire, McFarlane et al. (1981) Social Relationship Scale and The Multidimensional Scale of Perceived Social Support (Zimet et al., 1988).

Each question has a two part response. Firstly, the respondents are required to list the people in their environment who provide the support suggested by the question. Secondly, they are requested to rate their level of satisfaction with the support either as very satisfied, satisfied, dissatisfied or very dissatisfied, on a 4 point Likert scale. The questionnaire also allows the respondent to rate the accessibility of support, the proximity of the support and the mode of support.

4.3.3.1 Construction of Questionnaire

After selecting the items for the questionnaire, they were given to three psychiatrists and two clinical psychologists who had worked with African patients for over 10 years, for their opinions. There was general agreement among them that the questionnaire should also assess whether there is someone available at all times who would provide help, whether these persons were available immediately or lived a distance away, the mode through which social support is obtained (whether in person, by telephone or through the post) and the assessment of non-family support (for example, neighbours, priests and community leaders). Other suggestions included increasing the number of items so that items would be more specific and the re-phrasing of some items. These recommendations were assessed and several included in the questionnaire.

4.3.4 Symptom Inventory (SI)

An essential step in the process of seeking help for one's illness is the interpretation that the sufferer gives of the symptoms he or she experiences (Bishop, 1984; Mechanic, 1978; Pennebaker, 1982). Most often symptoms are ignored or go untreated and sometimes even serious symptoms are ignored (Bishop, 1984). According to Bishop and Converse (1986), it is essential to take into consideration the ways in which lay persons conceptualize physical symptoms and disease since this process plays a critical role in determining a person's health behaviour. For example, Matthews et al. (1983) showed that the interpretation given to symptoms of myocardial infarction influences the urgency of medical help-seeking as well as illness behaviour and sick role behaviour.

It was, therefore, also necessary to assess the perceptions and interpretation of the common symptoms in this study as well. The SI used in this study is a modified version of the Hopkin's Symptom Checklist (1974). The writer used the original 58 items and added 25 additional items to make the scale appropriate for the purpose of this study. The additional items were obtained through a process of interviews with several medical doctors from both the medical departments and psychiatric departments at the King Edward VIII Hospital. Those considered as common symptoms were included as the additional items.

The subjects had to indicated whether they had experienced the symptom and thereafter rate its severity on a four point Likert scale ranging from very serious to not serious. A category of not sure was also included.

It was envisaged that the present study could also be used to develop a standardised symptom inventory scale for South African conditions. See Appendix A.

4.3.5 Life Experience Survey (LES)

Two widely used instruments used for assessing life changes and experiences are the Schedule of Recent Experiences (Holmes and Rahe, 1967, and the Life Experience Survey (Sarason et al., 1978). A modified version of the Life Experience Survey was used in this study. The writer used the original scale in order to develop an instrument specifically useful for the South African context. As in the case of the SI the original items of the Life Experience Survey was expanded, in this instance by three additional items. The items that were included referred to the recent experiences of violence and the resultant effects in the population under study. The other modifications to this questionnaire included changing monetary values from U. S. dollars to South African equivalents.

4.4 TRANSLATION OF QUESTIONNAIRES

All questionnaires were translated into Zulu, the spoken language of the people participating in the study. The English version of the questionnaire was given for translation to two qualified and experienced health workers (a clinical psychologist and a psychiatrist), who have been working with African patients and who were fluent in both Zulu and English.

The translated questionnaire was then given to an independent health worker (a psychiatrist, who was fluent in both English and Zulu) to translate back into English. Wherever discrepancies were found, they were corrected. This method of back translation is an accepted method and is known to produce translations of a good quality. (Brislin, 1980). In addition, the translation and construction of all questionnaires were done in accordance with the guidelines and rules suggested by Retief (1988) on the writing and modifying of items for cross-cultural use.

It should be borne in mind that there is much variation in the Zulu that is spoken in the rural areas compared to that spoken in the townships and cities. The aim was to achieve a level suitable for the urban group being studied and to also make it understandable at a much broader level.

4.5 PILOT STUDY

Ten volunteers similiar to those required in the sample were asked to complete the HIB. At this stage the trained interviewers were qualified psychiatric nursing sisters. They were chosen because of their experience in social science research. The purpose of this phase was to ascertain problems interviewees may experience in completing the questionnaires, to identify any items that were perhaps ambiguous and to locate other difficulties that may affect the study.

This exercise proved to be very useful. Firstly, several ambiguous items emerged and were corrected. Secondly, some translation errors were identified. An example of such an error is the symptom “runny nose” which was translated “a nose that literally ran”. These translation errors were corrected. Thirdly, it was found that emotional, psychological and/or psychiatric items were being endorsed by respondents. The reason for this was the influence of the trained psychiatric nursing sisters. It was decided hereafter to use nursing sisters not trained in psychiatry and non-medical personnel.

This pre-test procedure also helped to assess the quality of the translation, a method suggested by Brislin (1980), who stated that the efficacy of this method depends on the control exercised during the testing and the extent to which the feedback is incorporated in the final revisions of the test. Both of these requirements, that is the strict control and the integration of feedback, were strictly adhered to.

CHAPTER 5

RESULTS

The results of the interviews and the findings of the questionnaires are presented in five main sections. The analysis of the data from questionnaire one is presented first, followed by the analysis of the Health Behaviour Questionnaire, the Social Support Questionnaire, the Symptom inventory and the Life Experience Survey, in that order.

5.1 DEMOGRAPHIC DATA

The age of the subjects in the Hospital Group ranged from 20 to 99 years (*Mn* = 33.23 years). The age of the subjects in the Umlazi Group ranged from 20 to 74 years (*Mn* = 34,88 years) and the Kwa Mashu Group had a range of 20 to 58 years (*Mn* = 33,41 years). The mean age for the three groups combined was 33.84.

Table III below gives a breakdown of the ages for each group. Most of the combined sample (90,71%) were in the 20 to 49 year group. Forty three percent of the sample were in the age group 20 to 29, 26% in the 30-39 year age group and 21% in the 40 to 49 year age group. There was no significant difference between the mean age for each group. Figure 6 represents the age distribution graphically.

TABLE III

AGE DISTRIBUTION OF GROUPS

		Age in years			
Group		20-29	30-39	40-49	50+
	N (%)	N (%)	N (%)	N (%)	
Hospital		173 (46.5)	93 (25.00)	66 (17.74)	40 (10.75)
Umlazi	151	(41.9)	91 (25.28)	86 (23.89)	32 (8.89)
Kwa Mashu		54 (37.0)	47 (32.19	35 (23.97)	10 (6.85)
Total		378 (43.1)	231 (26.31)	187 (21.30)	82 (9.34)

Table IV shows the ethnic distribution for each of the groups. The majority of the respondents were Zulu (85.09%). The next highest group was the Xhosa (9,94%). These two groups accounted for 95.03 % of the sample. The other groups comprised Sotho (N=9), Swazi (N=3), Tswana (N= 1) and Zanzibar (N=1). Unknown (N=29). However, all could speak Zulu.

TABLE IV
ETHNIC DISTRIBUTION

Group		Zulu		Xhosa		Other	
		N	(%)	N	(%)	N	(%)
Hospital		321	(85.83)	38	(10.16)	15	(4.01)
Umlazi	295	(86.01)	35	(10.20)	13	(3.79)	
Kwa Mashu		120	(81.08)	13	(8.78)	15	(10.14)
Total		736	(85.09)	86	(9.94)	43	(4.97)

TABLE V
EDUCATIONAL LEVEL OF GROUP

Level of Education	Hospital N (%)	Umlazi N (%)	Kwa Mashu N (%)	Total N (%)
No Education	53 (14.10)	22 (6.15)	18 (11.69)	93 (10.47)
Class i - Std 1	25 (6.65)	6 (1.68)	0 (0.00)	31 (3.49)
Std 2 - Std 4	46 (12.23)	25 (6.98)	4 (2.60)	75 (8.45)
Std 5 - Std 7	114 (30.32)	72 (20.11)	21 (13.64)	207 (23.31)
Std 8 - Std 10	123 (32.71)	184 (51.40)	98 (63.64)	405 (45.61)
Technikon/ college	5 (1.33)	38 (10.61)	9 (5.84)	52 (5.86)
University	10 (2.65)	11 (3.07)	4 (2.60)	25 (2.82)
Total	376	358	154	888

Table V provides a breakdown in 3 groupings of the educational level of those interviewed. A chi-square analysis revealed a significant difference between the level of education in the Hospital, Umlazi and Kwa Mashu Groups (χ^2 = 114, 49, $p<0.001$). The majority of the combined sample (68.92%) have a secondary school education. Approximately eleven percent had a primary school education and eight percent, a post matric qualification. The subjects in the Hospital Group appeared to have a lower level of education compared to the community samples. For example, a higher percentage of the Hospital Group had no formal education (14.10%) or primary level eduction (18.88%) than the community groups. (See Figure 7). Residence in an urban area ranged from 1 to 82 years. (Table VI provides the information regarding the terms of residence). A significant difference was found in the number of years each of the subjects in the groups have resided in an urban area (χ^2=30.46, $p<0.01$). Although most of the subjects had been living in an urban area for more than ten years, the Hospital sample had a higher percentage of subjects who had resided in urban areas for less than 10 years. (See Figure 8).

TABLE VI

YEAR DISTRIBUTION OF URBAN LIVING

	No. of Years			
Groups	**<5**	**5-10**	**>10**	**Total**
Hospital	**93(24.73)**	**34(9.04)**	**249(66.22)**	**376**
Umlazi	**39(10.77)**	**23(6.35)**	**300(82.87)**	**154**
Kwa Mashu	**23(14.95)**	**10(6.49)**	**121(78.57)**	**362**
Total	**155(17.38)**	**67(7.51)**	**870(75.11)**	**892**

The subjects in the Hospital Group (N=376) were referred to the hospital from districts throughout Natal and even beyond its borders. Table VII lists the subjects' residential areas. The hospital, however, is most frequented by patients in and around the Durban area. The south and north areas which has the highest representation (71.27%), naturally included the Umlazi and Kwa Mashu townships. Of the 38.56% of patients in the Durban (south) group, 29.5% were from Umlazi. The remaining subjects from this group (9.06%) resided in the Isipingo, Amanzimtoti, Malvern, Chatsworth and Merebank areas. Of the north group 32.71% of the patients from the Durban (north) area, 20.2% resided in Kwa Mashu. The remaining 12.51% of the south group came from the Inanda, Verulam, Tongaat and areas up to the Tugela River. The results suggest that the main catchment areas for this hospital extends from Amanzimtoti in the south to Pinetown and surrounding areas in the west, and the Tugela River in the north. This catchment area accounts for 82.97% of its patients.

TABLE VII
DESTINATIONS OF HOSPITAL SUBJECTS

District	N	%
Durban (south)	145	38.56
Durban (north)	123	32.71
Pinetown and surrounding area	36	9.04
Natal Midlands Pietermaritzburg and surrounding	14	3.72
Central South Umzinto and surrounding	12	3.19
South Port Shepstone and surrounding	10	2.66
Durban central and surrounding	10	2.66
North Tugela Zululand	7	1.86
Transkei	5	1.33
Northern Natal (Drakensberg area)	3	0.80
Lesotho	1	0.27
Unknown	10	3.20

A chi-squared analysis on the occupations of the subjects between the three groups showed significant differences (χ^2 = 171.52, p<0.01). Table VIII groups the occupations of the subjects according to the coding of occupation guide (Schlemmer and Stopforth, 1979). This guide was developed to encourage standardisation of the coding of occupations in South Africa. In addition, this guide was chosen because it was developed with careful consideration of codes for Africans. The subjects attending the hospital were found to be less skilled compared to those in the community groups (see Figure 9). However, a comparison of the community groups show that the Kwa Mashu Group have a higher percentage of semi-skilled artisans and professionals than the Umlazi Group.

TABLE VIII
SUBJECTS OCCUPATIONS

Group	Unskilled	Semi-skilled	Artisans	Middle White-collar	Profess-ional
Hospital	272 (72.34)	27 (7.18)	25 (6.65)	2 (0.53)	35 (9.31)
Umlazi 155	(42.82)30	(8.29)44	(4.93)11	(3.04)	79 (21.82)
Kwa Mashu	28 (18.18)	29 (18.83)	34 (22.08)	5 (3.25)	49 (31.82)
Total	455 (51.01)	86 (9.64)	103 (11.55)	18 (2.02)	163 (18.27)

5.2 TIME AND TRANSPORT COSTS OF HOSPITAL PATIENTS

The cost of travel incurred by patients attending the hospital ranged from R1.00 to R52.00. depending from where they came. The average cost was R6.27. This refers only to the cost of travel to the hospital and not other costs such as hospital fees and lunch.

Some patients left home as early as 2h00 to attend the hospital. All left by 8h00. On the average they arrived at the hospital 1 hour and forty three minutes later. Of those who attended the hospital, 160 (42.60%) reported that they were unemployed. Of those employed, 179 patients (47.60%) reported that they had to take the day off from work in order to attend the hospital. Forty-two (23.46%), who took the day off, reported that they would not get paid or compensated for loss of earnings.

The results show that 298 patients (79.26%) were unaccompanied to the hospital. Of the 20.74% who were accompanied, 21(26.92%) were accompanied by their spouse; 12 (15.38%) by their children; 5 (6.41%) by friends; 5 (6.40%) by their brothers; 3 (3.85%) by aunts and 3 (3.85%) by neighbours. In most of the cases patients were accompanied by females rather than males. A possible reason for this may be that the men more likely would be at work.

5.3 HELP SEEKING BEHAVIOUR OF HOSPITAL PATIENTS

In order to understand the factors and/or attitudes that influenced the patients medical help seeking behaviour, several open-ended questions were asked. The qualitative data obtained from these questions, are presented below. The data represents the views of the Hospital Group since only they had to complete this section.

Two hundred and twenty-one patients (59%) chose to attend King Edward VIII Hospital because they believed that it provided the best service for African patients. These patients felt that the services, facilities and treatment at the hospital were very good, that the hospital had plenty of doctors to attend to their needs and that the hospital was well known and recognized for its good treatment.

Forty-six (12%) of the patients chose to come to the hospital because they were referred by their general practitioner; 38 (10.3%) were either referred or transferred from another hospital or clinic. Twenty-six (7%) were encouraged to attend the hospital by their employers or family members because they thought that the hospital provided the best treatment.

The term spouse is used inclusively of boyfriend or girlfriend, since couples live together and only regard their partner as a spouse when the lobola has been paid. Lobola refers to the payment of bride price or dowry, that the husband is required to pay the brides father.

Eight patients (2.2%) attended the hospital because they felt that the cost of treatment was much cheaper than other hospitals. Seven subjects (1.9%) did not respond or gave inappropriate answers.

5.3.1 Choice of Day to Attend

Two hundred and ninety-six of the 376 patients responded to the question that addressed the choice of day to attend the hospital.

The majority of patients (N=149, 50.34%) attended on the day they felt that they were either getting worse, their condition was deteriorating or that their pain was becoming unbearable. In eighty-six cases (29.05%) the day of attendance was determined either by an appointment or because they felt that the hospital will not be busy. Twenty-three (7.77%) had to wait to get paid because they did not have sufficient money to attend.

About 21 (7.1%) attended on the day their referring doctor had arranged an appointment with the hospital. A small number, 8, (2.70) reported that they were too busy at work or school and had no time to attend earlier. Seven had to wait for transport (2.4%); 1 patient had to arrange for someone to look after her children and another attended on the advise and insistence of a friend.

5.3.2 Patient's First Suspicions of Illness and Attendance

The majority of patients attended the hospital within a month of suspecting they were ill. One hundred and thirty-five (35,9%) attended within a week, 42 (11,2%) within 2 weeks, 20 (5,3%) by the third week and 45 (12,0%) by the fourth week — a cumulative percentage of 65,4% (N=246). The mean attendance over a year period was 5,85 weeks (SD. 9,82). Table IX provides a breakdown of the attendance. Figure 10 depicts the attendance graphically.

TABLE IX
ILLNESS PRECIPITATION AND ATTENDANCE TO HOSPITAL

Week/s	N	%
≤ 1	135	35.9
≤ 2	42	11.2
≤ 3	20	5.3
≤ 4	45	12.0
5- 8	34	9.0
9-12	11	3.0
13-16	6	1.7
17-20	4	1.1
21-24	5	1.4
25-28	5	1.4
29-32	7	1.9
49-52	8	2.2
>1 year	50	13.9

5.3.3 Patients Reasons for not Attending Earlier

One hundred and sixty-two patients (43,50%) did not attend the hospital earlier because they felt that their illness was not serious enough, that the symptoms did not bother them or they denied any illness existed. These patients felt that they would get better without any medical intervention. Seventy-four (19,90%) were seeing a private doctor or attending another clinic or hospital. “No money” was given by 55 (14,80%) as a reason for not attending earlier. Eight (2,20%) went to a pharmacy for help. Seven (1,90%) of the patients indicated this was the earliest appointment they could get. Seven (1,90%) had either no transport or no one to bring them to the hospital. Six (1,60%) described themselves as being too seriously ill to attend. One reported that the illness remitted for a short while, whereas another patient went to “church people” for help. One of the patients reported that she was too afraid to come earlier. Eleven (3,00%) felt that they had not delayed. (See Figure 11).

5.3.4 Feelings or experiences that suggested to the patients that they were Ill

Two hundred and thirty-eight patients (63,3%) felt that they were sick because they experienced only physical symptoms. Sixty-four (20,8%) felt they were sick because they had experienced only psychological symptoms, such as, forgetfulness, worry, or depression, as well as changes in affect, sleep patterns, energy levels and decreased appetite. Two hundred and forty-three (79,2%) had a combination of physical and psychological symptoms.

Three hundred and twenty-seven patients (87,0%) were worried about the symptoms they were experiencing as opposed to 42 (11,2%) who were not really concerned although they felt they were sick.

As many as 148 (46,2%) patients did not know what was wrong. The responses of those who felt that they did know what was wrong with them were varied. Forty-three (13,4%) thought they had flu; 40 (12,5) felt that their illness was due to some form of infection because there were visible signs, such as, sores or lacerations. Twenty-six (8,1) thought that they had a terminal illness such as cancer or AIDS and that they were going to die.

Other explanations included, 17 (5,3%) who felt that there was something wrong with their blood, that their bladder was dirty or that they had water in their heads. Twelve (3,7%) felt that their illness was due to witchcraft, the crossing of a path where some ritual was performed, the inhaling of a bad spirit or that they were poisoned by someone. Twelve (3,7%) felt that it was some known clinical syndrome, such as, diabetes, asthma or high blood pressure. 11 (3,4%) felt that their illness was the result of normal developmental processes, such as, puberty, pregnancy and old age. Nine (2,8%) attributed their illness to seasonal or temperature changes and 2(0.6%) felt that it was due to a past surgical procedure.

5.3.5 Illness Disclosure

Three hundred and twenty-two (86%) of the hospital patients talked about their illness and concerns to others prior to attending the hospital while only 49 (13,2%) did not. Of those who did speak to others, 92 (28,3%) had spoken to their mothers; 76 (23,4%) to their spouses or boy/girlfriends; 30 (9,2%) to friends; 21 (6,5%) to their children; 20 (6,2%) to their employer; 17 (5,2) to a sister; 12 (3,7%) to a brother; 12 (3,7%) to a relative; 10 (3,1) to their father; 7 (2,2%) to both parents and 5 (1,5%) to their grandmother. Only 8 (2,5%) had spoken to a doctor.

5.4 SERVICES

5.4.1 Choice of doctor, hospital and pharmacy by the community groups.

The choice of a doctor by individuals in the community sample groups are reflected in Table X. The subjects were asked to indicate the location of a doctor they would visit if they had to and why they would choose that particular doctor. It appears from the responses that there is a tendency, naturally, for people to use services that are the closest to them (58.6%).

TABLE X
LOCATION OF DOCTOR

Choice	Umlazi		Kwa Mashu		Total	
	N	(%)	N	(%)	N	(%)
Within township	211	(63.7)	66	(42.9)	277	(58.6)
Outside township	106	(32.1)	54	(35.1)	160	(33.8)
City	3	(0.9)	21	(14.8)	24	(5.1)
Staff Doctor	5	(1.5)	1	(0.7)	6	(1.3)
Anywhere	6	(1.8)	0		6	(1.3)
Total	331		142		473	

The reasons for choosing a particular doctor are listed in Table XI. The main factors that seem to motivate the choice of a doctor are the proximity and quality of service. The majority chose a doctor closest to them (34.9%) or because they perceived that they would get good service (28.6%). Only 11.6% considered cost in the choice of a doctor.

TABLE XI
REASONS FOR CHOOSING A DOCTOR

Reason/s	Umlazi N (%)	Kwa Mashu N (%)	Total N (%)
Nearest	140 (38.5)	43 (30.5)	183 (34.9)
Good service	98 (25.6)	52 (36.9)	150 (28.6)
Family doctor	67 (17.5)	9 (6.4)	76 (14.5)
Cheapest	42 (11.0)	19 (13.5)	61 (11.6)
Nearest to work	18 (4.7)	14 (9.9)	32 (6.1)
Staff services	13 (3.4)	4 (2.8)	17 (3.2)
Medical aid	5 (1.3)	_	5 (0.9)
Total	383	141	524

The choice of hospital and the reasons for their choice are found in Table XII and Table XIII respectively. Here again, the proximity and quality of service play an important role in the choice of services. King Edward VIII Hospital is still preferred by both communities although Prince Mshiyeni Memorial Hospital (which is in Umlazi) is equally popular in the Umlazi community. However, Kwa Mashu does not have a hospital close to them which accounts for the higher number of patients attending King Edward VIII Hospital from there. These results also show that as much as 12.8 % use private services. The fact that 44.9% felt that their choice of hospital was determined according to the quality of service and 33.8% because it was nearest to them, supports the view that convenience and quality of service are the most important factors for use of these services.

TABLE XII
CHOICE OF HOSPITAL

Hospital	Umlazi		Kwa Mashu		Total	
	N	(%)	N	(%)	N	(%)
King Edward VII	122	(35.3)	84	(58.4)	206	(40.7)
Prince Mshiyeni	147	(42.5)	9	(6.3)	156	(30.8)
Private (Indian,city)	18	(5.2)	17	(11.9)	35	(6.9)
Clairwood	31	(8.9)	1	(0.6)	32	(6.3)
McCords	-		16	(11.2)	16	(3.2)
Medical Towers	14	(4.0)	1	(0.6)	15	(3.1)
Private (White, city)	9	(2.6)	5	(3.5)	14	(2.8)
St. Mary's	1	(0.3)	4	(2.7)	5	(1.0)
King George V	3	(0.9)	-		3	(0.6)
Kwa Dabeka Day	-		3	(2.1)	3	(0.6)
Addington	-		3	(2.1)	3	(0.6)
Madedeni	1	(0.3)	1	(0.6)	2	(0.4)
Total	350		156		506	

TABLE XIII
REASONS FOR CHOOSING A HOSPITAL

Reason/s	Umlazi		Kwa Mashu		Total	
	N	(%)	N	(%)	N	(%)
Good service	119	(34.0)	108	(69.2)	227	(44.9)
Nearest	146	(41.8)	25	(16.1)	171	(33.8)
Nearest to work	50	(14.3)	10	(6.4)	60	(11.9)
Cheapest	19	(5.4)	8	(5.1)	27	(5.3)
Referred	12	(3.4)	5	(3.2)	17	(3.4)
Medical Aid	3	(0.8)	-		3	(0.6)
No referral required	1	(0.3)	-		1	(0.2)
Total	350		156		506	

The choice of a pharmacy (Tables XIV and XV) is in keeping with choices of other services. These tables show that proximity and quality of service are the most important factors related to choice of medical and health services.

TABLE XIV
CHOICE OF PHARMACY

Location	Umlazi N (%)	Kwa Mashu N (%)	Total N (%)
Local township	143 (49.7)	46 (35.1)	189 (44.7)
City	93 (31.8)	45 (34.4)	138 (32.6)
Outside township	47 (16.1)	37 (28.2)	84 (19.9)
Anywhere	7 (2.4)	3 (2.3)	10 (2.4)
Total	292	131	423

TABLE XV
REASONS FOR CHOOSING A PHARMACY

Reason/s	Umlazi N (%)	Kwa Mashu N (%)	Total N (%)
Nearest	100 (33.0)	54 (37.8)	154 (34.5)
Good service	67 (22.1)	31 (21.6)	98 (22.0)
Nearest to work	67 (22.1)	23 (16.1)	90 (20.2)
Cheapest	44 (14.5)	7 (4.9)	51 (11.4)
Well stocked	19 (6.3)	20 (14.0)	39 (8.7)
Trust them	3 (0.9)	7 (4.9)	10 (2.2)
Referred	3 (0.9)	1 (0.6)	4 (0.9)
Total	303	143	446

5.5 SUBJECTS PERCEPTIONS OF TREATMENT

The majority in the sample (n=739, 83,8%) who had received medical services from a private doctor or a hospital reported that they were pleased with the treatment. χ^2=93.18 (p<0,01) was obtained. See Table XVI for each of the groups responses. It appears, however, that the community samples, Umlazi (83.9%) and Kwa Mashu (84.7%) were generally more pleased with treatment at the hospital than the Hospital group (53.2%).

TABLE XVI
SUBJECTS PERCEPTIONS OF TREATMENT

Perception	Hospital N (%)	Umlazi N (%)	Kwa Mashu N (%)	Total
Pleased with Rx	152 (53.2)	281 (83.9)	111 (84.7)	544 (72.3)
Not pleased with Rx	89 (31.1)	24 (7.2)	10 (7.6)	123 (16.4)
Not sure	45 (15.7)	30 (9.0)	10 (7.6)	85 (11.3)
Total	286	335	131	752

The two factors that pleased patients most about their treatment were that their illnesses were cured (N=224, 37.71%) and the service and care were very good (N=330, 55.55%). Table XVII lists the aspects the subjects were most pleased with and Table XVIII lists those aspects of treatment that respondents were not pleased about.

TABLE XVII
TREATMENT FACTORS SUBJECTS WERE PLEASED ABOUT

Factors	Hospital N (%)	Umlazi N (%)	Kwa Mashu N (%)	Total N (%)
Good service and care	83 (48.0)	167 (54.4)	80 (70.2)	330 (55.5)
Illness cured	78 (45.1)	117 (38.1)	29 (25.4)	224 (37.7)
Gave injection	5 (2.9)	19 (6.2)	2 (1.8)	26 (4.4)
Gave medication	4 (2.3)	4 (1.3)	3 (2.6)	11 (1.9)
Cost	2 (1.1)	-	-	2 (0.3)
Gave Rx never seen before	1 (0.6)	-	-	1 (0.2)
Total	173	307	114	594

TABLE XVIII
TREATMENT FACTORS SUBJECTS WERE NOT PLEASED ABOUT

Factors	Hospital (N=146)	Umlazi (N=133)	Kwa Mashu (N=54)	Total (N=333)
Poor Dr-Pt relationship	38 (26.0)	72 (54.1)	31 (57.4)	141 (30.3)
Poor facilities	21 (14.4)	67 (50.4)	34 (63.0)	122 (26.2)
Time delays	17 (11.6)	52 (39.1)	17 (31.5)	86 (18.5)
Illness not cured	67 (45.9)	15 (11.3)	2 (3.7)	84 (18.1)
Cost	10 (6.8)	18 (13.5)	4 (7.4)	32 (6.9)

A significant number of the subjects (N=702, 92,2%) were willing to seek medical services in the future (χ^2=2,359, p<0,01). Whereas 24 (3,1%) did not want to and 37 (4,7%) felt that they were not sure if they would seek medical treatment again.

Table XIX shows that patients obtain their medication through consultations with medical doctors. A very small percentage obtained medication from pharmacies or friends. As to why they were given medication patient responded thus: 352 (46,8%) knew that they had to take medication because of their illness although they did not understand the nature of the illness; 304 (40,4%) took medication having understood quite well the nature of their illness. Only a significant few ($p<0,01$) prescribed medication for themselves because they felt they had the flu (5,1%) or because they had pain (7,7%).

TABLE XIX
SOURCES OF MEDICATION

Source	Hospital (N=296)	Umlazi (N=334)	Kwa Mashu (N=130)	Total
Private doctor	177 (59.8)	207 (62.0)	48 (36.9)	432 (57.1)
Clinic/ hospital	77 (26.0)	104 (31.1)	66 (50.8)	247 (32.6)
Pharmacy	24 (8.1)	16 (4.8)	-	40 (5.3)
Staff doctor	12 (4.1)	6 (1.8)	13 (10.0)	31 (4.1)
Friends/ relatives	6 (2.0)	1 (0.3)	-	7 (0.9)

There were significant differences in the way the subjects responded to whether western medicines were beneficial to them. Table XX lists the responses. Differences occurred between the Hospital and the community group. Western medications were perceived by the hospital attenders as being less beneficial.The Hospital Group (20.00%) demonstrated greater doubt about the efficacy of western medication than both community groups; Umlazi (5.1%) and Kwa Mashu (5.4%)

TABLE XX
SUBJECTS PERCEPTIONS OF WESTERN MEDICINES

Perception	Hospital		Umlazi		Kwa Mashu		Total	
	N	(%)	N	(%)	N	(%)		
Helpful	160	(51.6)	299	(89.5)	116	(89.9)	575	(74.4)
Not helpful	88	(28.4)	18	(5.4)	6	(4.7)	112	(14.5)
Not sure	62	(20.0)	17	(5.1)	7	(5.4)	86	(11.1)
Total	310		334		129		773	

With regard to the use of vitamin supplements, 466 (53.1%) did not take supplements whereas 412 (46.9 %) respondents reported having used them. More of the Kwa Mashu Group (55.7%) used vitamin supplements than the Umlazi Group (40.4%). (χ^2=141.76, $p<0.05$). The reason for taking vitamin supplements also significantly differed between the groups ($p<0.01$). See Table XXI.

TABLE XXI
REASONS FOR TAKING VITAMINS

Reason/s	Hospital (N=184)	Umlazi (N=145)	Kwa Mashu (N=88)	Total
Increase strength	66 (35.9)	77 (53.1)	32 (36.4)	175 (42.0)
Health/ active protective	40 (21.7)	33 (22.8)	22 (25.0)	95 (22.8)
Cure/ treat illness	29 (15.8)	7 (4.8)	17 (19.3)	53 (12.7)
Blood supplement	12 (6.5)	8 (5.5)	8 (9.1)	28 (6.7)
Advised (non-medical)	11 (6.0)	9 (6.2)	8 (9.1)	28 (6.7)
None	26 (14.1)	11 (7.6)	1 (1.1)	38 (9.1)

5.6 RELIGIOUS AND CULTURAL BELIEFS

Table XXII provides a break down of the religious and cultural affiliations of the three groups. Eighty-nine percent of the total sample were Christian, 6.6% belonged to traditional African religious groups, 2.8% 'other' and 1.4% claimed to belong to both Christian and Traditional religion.

TABLE XXII
RELIGIOUS AND CULTURAL BELIEFS

Beliefs	Hospital (N=357)	Umlazi (N=343)	Kwa Mashu (N=151)	Total
Christian	317 (88.8)	321 (93.6)	121 (80.1)	759 (89.2)
Traditional	21 (5.9)	17 (5.0)	18 (11.9)	56 (6.6)
Other	10 (2.0)	2 (0.6)	12 (7.9)	24 (2.8)
Christian and traditional	9 (2.5)	3 (0.9)	-	12 (1.4)

Subjects responses to seeking traditional healing for their illnesses are found in Table XXIII. Help from traditional healers were sought by 14.5%; 24,4% visited faith healers and 5.67% sought help from both traditional and faith healers.The majority of the subjects reported non-use of traditional religious services (55.4%). There appears to be a greater rejection of these traditional services by both the Hospital Group (57.4%) and the Umlazi Group (58.7%). Of those that use traditional services, faith healers are frequented more often than traditional healers.

TABLE XXIII
USE OF TRADITIONAL HEALERS.

Type	Hospital (N=357)	Umlazi (N=339)	Kwa Mashu (N=151)	Total
None	205 (57.4)	199 (58.7)	65 (43.1)	469 (55.4)
Faith Healer	93 (26.1)	76 (22.4)	38 (25.2)	207 (24.4)
Traditional healer	42 (11.8)	51 (15.1)	30 (19.9)	123 (14.5)
Traditional and faith healer	17 (4.8)	13 (3.8)	18 (12.0)	48 (5.67)

The treatments administered by these healers are listed in Table XXIV. The subjects reported that the treatment very often was a combination of methods. Holy water (64.44%) and herbs (24.60%) are most often used. Although they are faith healers prayer is used in only 13.63% of the cases who approached these healers for help.

TABLE XXIV
TREATMENT GIVEN

Treatment	Hospital (N=148)	Umlazi (N=87)	Kwa Mashu (N=139)	Total
Holy water	100 (67.6)	63 (72.4)	51 (36.7)	241 (64.44)
Herbs	26 (17.6)	47 (54.0)	19 (13.7)	92 (24.60)
Trad. medicines	36 (24.3)	13 (14.9)	19 (13.7)	68 (18.18)
Prayer	13 (8.8)	17 (19.5)	21 (15.1)	51 (13.63)
Candles	3 (2.0)	11 (12.6)	5 (3.6)	19 (5.08

The frequency of visits to traditional healers is listed in Table XXV. Subjects generally consulted traditional healers for about 3 times and thereafter there appears to be a decline in attendance. Of those who sought traditional healers, 33.8% attend more than 6 times.

TABLE XXV
FREQUENCY OF VISITS TO TRADITIONAL HEALERS

No of visits	Hospital (N=150)	Umlazi (N=139)	Kwa Mashu (N=87)	Total
1	38 (25.3)	18 (12.95)	7 (8.1)	63 (17.0)
2	39 (26.0)	37 (26.6)	22 (25.3)	98 (26.1)
3	24 (16.0)	19 (13.7)	14 (16.1)	57 (15.2)
4	1 (0.7)	3 (3.5)	1 (0.7)	10 (2.7)
5	5 (3.3)	13 (9.4)	3 (3.5)	21 (5.6)
6+	43 (28.7)	33 (38.0)	51 (36.7)	127 (33.8)

The average payment per treatment to the traditional healers varied for each group: the Hospital Group (R84.62), the Umlazi Group (R68.23) and The Kwa Mashu Group (R95.29).

There were significant differences ($p<0.01$) between the groups about how they felt about the usefulness or benefit of the traditional or cultural treatment. Table XXVI shows that 80.5% of the Kwa Mashu Group felt that the traditional treatments were beneficial whereas only 40.4% of the Hospital Group and 64.3% of the Umlazi Group felt it was beneficial. However, the Hospital Group indicated greater displeasure with traditional treatments.

TABLE XXVI
SUBJECTS PERCEPTIONS OF THE EFFECTIVENESS OF TRADITIONAL TREATMENT

Perception	Hospital (N=151)	Umlazi (N=140)	Kwa Mashu (N=87)	Total
Rx helped	70 (40.4)	90 (64.3)	70 (80.5)	230 (60.9)
Rx did not help	40 (26.5)	13 (9.3)	7 (8.1)	60 (15.9)
Not sure	41 (27.2)	37 (26.4)	10 (11.5)	88 (23.3)

Rx = treatment

The data in Table XXVII supports the view that of those who used traditional treatment methods, an overall 47.40%, will continue traditional treatment. A $p<0,05$ significance was obtained between the groups ($\chi^2=35.65$). A greater number in the Hospital Group (58.55%) indicated that they will continue traditional treatment than the Umlazi Group (38.88%) and Kwa Mashu Group (42.22%)

TABLE XXVII
CONTINUATION OF TRADITIONAL TREATMENT

	Hospital (N=152)	Umlazi (N=144)	Kwa Mashu (N=90)	Total
Cont. trad. Rx	89 (58.55)	56 (38.88)	38 (42.22)	183 (47.40)
Discont. trad Rx	63 (41.5)	88 (61.1)	52 (57.8)	203 (52.6)

Rx = treatment

Table XXVIII indicates the use of prayer by individuals as a method of 'treatment' for their illness. Prayer is most often sought from church people, such as, ministers, deacons and woman's prayer groups, (50,0%). Other sources from which prayer is sought are the family (25,4%) and friends or neighbours (16,4%).

TABLE XXVIII
PRAYER AS A TREATMENT FOR ILLNESS

	Hospital		Umlazi Kwa Mashu		Total	
	N	(%)	N	(%)	N	(%)
Pray	59	(16.1)	65	(18.8)	50	(35.5)	174	(20.4)
Do not pray	308	(83.9)	281	(81.2)	91	(64.5)	680	(79.6)
Total	367	(43.0)	346	(40.5)	141	(16.5)	854	

Twenty-one percent reported consulting a herbalist for their illness. See Table XXIX. There is significantly greater use of herbalist by the community groups than the Hospital Group (χ^2=6.23, p<0.05).

TABLE XXIX
CONSULTATION OF HERBALISTS

	Hospital		Umlazi Kwa Mashu		Total	
	N	(%)	N	(%)	N	(%)
Herbalist seen	61	(16.5)	77	(21.8)	45	(30.4)	183	(21.0)
Herbalist not seen	309	(83.5)	276	(78.0)	103	(70.0)	688	(79.0)
Total	370	(42.4)	353	(41.0)	148	(17.0)	872	

Several folk medicines were reported to have been used. Laxatives appear to be the most popular substance consumed. Table XXX provides a breakdown of the substances each group used.

TABLE XXX
USE OF TRADITIONAL OR "LAY" SUBSTANCES

Substance	Hospital N (%)	Umlazi N (%)	Kwa Mashu N (%)	Total N (%)
Laxatives	316 (84.0)	328 (90.6)	138 (90.0)	782 (88.0)
Ointments	135 (35.9)	145 (40.1)	63 (41.0)	343 (38.5)
Vomiting meds.	130 (35.0)	106 (29.3)	74 (48.1)	310 (35.0)
Strengthening meds. 135	(36.0)118	(33.0) 38	(25.0)291	(33.0)
Holy water	124 (33.0)	105 (29.0)	47 (31.0)	276 (31.0)
Herbs	78 (20.7)	69 (19.1)	53 (34.4)	200 (22.4)
Hot/cold preparations	40 (10.6)	41 (11.3)	38 (25.0)	119 (13.3)
OTHER.....				
Glucose	42 (11.1)	55 (15.2)	2 (1.3)	99 (11.1)
Castor oil	42 (11.1)	35 (9.7)	6 (4.0)	83 (9.3)
Warm water	42 (11.1)	32 (8.8)	1 (0.6)	75 (8.4)
Epsom salts	16 (4.3)	19 (5.2)	1 (0.6)	36 (4.0)

5.7 HEALTH AND ILLNESS BELIEFS (QUALITATIVE RESPONSES)

The subjects were asked to respond to several open-ended question about health and illness beliefs. Below is a summary of their responses.

5.7.1 What is wrong with you and why do you think so?

Only the Hospital Group had to respond to this question because it was most appropriate for these subjects since they were seeking medical help at the hospital. Of those that answered 43.40% (n=152) did not know what was wrong with them. The most common explanations for their symptoms were: 14.00% (n=51) understood these symptoms as a

recognized medical disorder; 11.80% (n=43) felt it was due to infection; 6.00% (n=22) felt is was a result of ‘something wrong with the blood (that is, their blood was either dirty or weak), that they had too much of gall in the body, their body was weak or they had dirty organs'; 4.40% (n=16) felt that it was due to injury; 4.10% (n=15) due to bewitchment, evil or evil spirit possession, crossing a path where a ritual was performed or as a result of the ancestors being angry; 2.50% (n=9) old age; 2.20% (n=8) poor nutrition, the use dirty drinking water or poor living conditions and 1.70% (n=6) felt that it was due to their brain not functioning properly. Other less common reasons were seasonal changes 0.80% (n=3), alcohol and drug abuse 1.10% (n=4), body malfunctioning 1.10% (n=4), side effects of medication 0.80% (n=3), anger 0.80% (n=3) and temperature change 0.50% (n=2)

The reasons they gave for making the above 'diagnoses' were: 38.80% (n=132) gave a reasonable explanation; 13.80% (n=47) because they had physical symptoms and/or, they were not functioning as they had previously; 2.10% (n=7) had been told so by others; 1.80% (n=6) because of cognitive changes and/or vegetative shifts; 0.6% (n=2) cessation of tradition beliefs or belief in God and 0.30 (n=1) environmental change.

5.7.2 What does it mean to be sick?

The respondents experienced difficulty responding to this question. Most responded to this question as feeling "nauseous", "to vomit" or "feel weak". There appeared to be no difference in the concept between sick and ill. The term 'ukugula' is used most often for being or feeling ill.

5.7.3 What does it mean to be ill?

Patients responses to this question are found in Table XXXI below. Generally illness meant not feeling well or 'free' in the body, soul and life; not feeling good or normal; being worried, having problems, being uncomfortable and unrelaxed; perceiving pain; and

experiencing physical and psychological symptoms. The responses made show that the subjects hold an holistic view of illness. Biopsychosocial symptomatology is considered as cause or reasons for illness.

5.7.4 What does it mean to be well ?

The subjects view of health is in keeping with their view of illness. Yet again the subjects hold a holistic view of health. Wellness is associated with feeling 'free' and good in body, soul and life in general; having no worries, problems, feeling comfortable and relaxed; no perception of pain and no physical or psychological symptoms. Their responses are found in Table XXXII.

TABLE XXXI
MEANING OF BEING ILL

Meaning	Hospital (376) %	(362) %	Umlazi Kwa Mashu (154) %	(892) %	Combined
Do not feel well/free in your body/ soul/life, do not feel good, normal worried, have problems, uncomfortable, not relaxed	76.90		65.50	63.60	70.00
Pain	15.70		32.00	39.00	26.30
Ineffective, unproductive	9.31		8.84	14.90	10.10
Unhappy, sad (facial and mood change)	6.64		7.46	6.49	7.00
Do not look physically well/ healthy, not strong, fit physically	8.20		12.99	16.88	11.70
Not lively, active, or energetic-slowed	3.46		6.63	11.04	6.10
Body organs not functioning 2.13	7.73		7.79	5.40	
Have symptoms	3.19		6.63	4.55	4.80
Have infection/ disease	3.39		0.55	12.99	3.50
Something foreign in the body	0.80		5.25	0.65	2.60
Poor appetite	2.39		2.76	5.19	3.00
Sleep poor	3.19		2.76	1.95	2.80
Dependent (self care)	1.06		2.49	1.95	1.80
Need for doctor/hospital	2.13		0.28	0.65	1.10
Something wrong with blood	1.86		-	0.65	0.90
Going to die	1.06		-	-	0.40
Asocial, withdrawn	-		0.55	0.65	0.30
Imbalance mentally, physically and emotionally.	-		-	1.30	0.20
Bewitched/ bad spirit 0.53	-		-	0.20	

TABLE XXXII
MEANING OF BEING WELL

Meaning		Hospital (376) %	Hospital (362) %	Umlazi Kwa Mashu (154) %	Umlazi Kwa Mashu (892) %	Combined
Feel well in your body and soul, feeling good, normal, no worries, problems, free in your soul, life, enjoying life/content		64.63	53.04	45.45		56.61
Healthy, good weight, strong, fit, physical		32.45	48.07	57.14		43.05
No pain		21.28	29.56	25.97		25.45
Happy, excited,joy		28.46	21.27	13.64		22.99
Lively, active, energetic		14.10	13.26	14.29		13.75
Effective, productive	9.04	8.01	18.18	10.20		
Psychologically and mentally fit		3.29	5.80	14.29		5.83
Body organs functioning		1.60	4.97	6.49		3.81
No infection/ disease		1.60	1.93	13.64		3.81
Good appetite	2.39	3.31	1.30	2.58		
Independent		4.26	0.28	2.60		2.35
No symptoms		0.79	2.21	3.90		1.91
No need for doctor/hospital		2.13	0.28	1.95		1.35
Visiting others	1.33	0.83	2.60	1.35		
Bewitched/ bad spirit	0.27	-	-	0.11		

The subjects' responses to what they believed that the indicators of 'being well' and 'being ill' were, are found respectively in Table XXXIII and Table XXXIV. Physical ability, mood and psychological well-being are considered indicators of being well. Poor vegetative function, physical ability, mood as well as phycological well-being is considered indicators of 'being ill'.

TABLE XXXIII
INDICATORS OF BEING WELL

Meaning	Hospital (376) %	(362) %	Umlazi (154) %	Kwa Mashu (892) %	Combined
Strong, fit, physical	28.19		38.95	38.31	34.30
Happy, excited,joy, singing, dancing, laughs, jokes, humour	27.39	24.59	43.51	29.04	
Lively, active, energetic		30.59	10.54	24.03	27.58
To work properly, works hard, effective, productive		16.76	25.41	31.17	22.76
Health, good weight, not neglected		6.84	23.20	12.37	18.39
Good, normal, feel well in your body, free in your soul, life, enjoying life/content, comfortable		18.09	16.02	20.78	17.71
Good appetite	15.96	16.22	13.64	15.92	
No pain		7.45	11.88	18.18	11.09
Facial expression		9.84	12.99	1.95	9.75
Mobility		9.57	5.80	5.19	7.29
Playing with others, not visiting others		8.78	4.97	6.49	6.84
Quick, sharp, concentrate		4.52	7.46	7.79	6.39
Symptoms		3.46	7.18	13.64	6.73
Talks properly, loud		5.05	5.52	8.44	5.83
Sleep well		3.99	5.25	4.55	4.59
Psychologically and mentally fit, talk appropriately		0.80	2.49	9.09	2.91
Change of attitude, motivated		1.86	3.31	-	2.13
No need for doctor/hospital		2.39	0.55	0.65	1.34
Agitated not relaxed		0.53	0.28	-	0.34

TABLE XXXIV
INDICATORS OF BEING ILL

Meaning	Hospital (n=376) %	Umlazi Kwa Mashu (n=362) %	Combined (n=154) %	(n=892) %
Good appetite 39.36	47.79	26.62	40.58	
Not lively, active, energetic	37.23	35.36	44.14	37.67
Sleep well	22.61	25.69	14.29	22.42
jokes, humour, happy, excited, joy	23.67	11.33	35.71	20.74
Health, good weight, neglected	16.49	24.03	14.29	19.17
Works hard, effective, productive	15.69	12.15	22.73	15.47
Pain	9.31	17.40	27.92	15.81
No symptoms	8.51	15.47	8.44	11.32
Vomit, nausea 6.12	14.36	3.90	9.08	
Dizzy, faint, weak	9.31	10.22	5.19	8.97
Not good, normal, do not feel well in body, not free in soul, life, not enjoying life, not content, worried, problems, uncomfortable	11.44	3.59	11.69	8.29
Talks properly, loud	5.05	8.84	7.79	7.06
Strong, fit, physical	4.52	8.84	4.55	6.28
Quick, concentrate, psycho-logically and mentally fit	2.13	9.39	5.84	5.72
Normal body temp	3.46	5.25	10.39	5.38
No need for doctor/ hospital	6.64	2.49	0.65	3.92
Not visiting others	1.33	7.18	4.55	4.26
Change of attitude, motivated	4.26	2.49	7.79	4.15
Mobility	3.72	3.04	3.25	3.36
Agitated not relaxed/ aggressive	2.39	2.49	6.49	3.14
Independent	0.80	1.66	6.49	2.13
Facial expression, laughs, cries	1.06	2.76	1.30	1.79
Body organs functioning	0.27	0.28	4.55	1.01

TABLE XXXV
REASONS PEOPLE GET SICK/ ILL

Reasons	Hospital (n=376) %	Umlazi Kwa Mashu (n=362) %	Combined (n=154) %	(n=892) %
Diet, poor nutrition, junk food	63.03	76.52	53.25	66.82
Cold while sleeping, no or poor shelter, dirty, squatter conditions, drinking dirty water, pollution, poor environments	62.24	73.48	63.64	66.45
Disease/ infection, germs	11.70	10.77	23.38	13.34
No exercise	6.64	21.82	11.69	13.68
Psychological problems, worry, bad thoughts/ moods, stress	9.57	10.77	25.97	12.89
Non-compliant to Drs Rx, not going for regular check ups, delaying/ procrastinating attendance to doctors	7.98	9.94	14.29	9.86
Large consumption of alcohol	6.91	7.18	11.69	7.85
Belief and following traditional Rx.	10.90	2.47	10.39	7.50
Not keeping yourself healthy	5.057.18	3.90	5.72	
Poverty	1.33	3.59	20.13	5.49
Over crowding	2.663.87	15.58	5.38	
Social problems	6.12	3.59	7.14	5.27
Smoke excessively	1.33	6.63	5.19	4.15
Injuries, accidents, violence, war, unrest	3.46	3.59	1.95	3.25
Poor health facilities/ apartheid	1.60	3.04	5.19	2.80
Increased responsibility	2.66	3.31	0.65	2.58
Laziness	1.33	1.66	6.49	2.35
Forget God	-	1.38	3.25	2.32
Substance abuse	1.06	3.87	1.30	2.24
Season or weather changes	1.06	3.31	2.60	2.24
Weak, not strong	1.33	1.38	5.84	2.13
Overworking	1.06	0.83	3.25	1.34
Allergic, taking something not good for your body	0.53	2.76	0.65	1.64
Something foreign enters				

their body	-	2.49	0.65	1.57
Poor education	-	-	1.30	1.30
To die	-	1.10	-1.10	
Loss of culture	1.06 0.28	1.95	1.10	
Bewitchment	-	0.55	1.30	0.93
Body malfunctioning	0.53	0.55	2.60	0.90
Not resting or relaxing	0.27	1.38	1.30	0.90
Old age	1.33	0.55	-	0.78
Attack without a cause, natural	0.27	0.28	1.30	0.62
Promiscuity	1.06	0.28	-	0.56
Inherited	-	0.28	0.65	0.47
Bad terms with neighbours/ family	0.79	0.28	0.65	0.45
Insufficient sleep	0.27	0.55	-	0.34
Malingering	-	0.28	-	0.28
No support	-	0.28	-	0.28
Don't clean their stomachs	0.27	0.28	-	0.22

Table XXXV lists the responses the subjects made to the question, 'why people get ill?' Poor nutrition and diet, poor living conditions and poverty were the main reasons given for getting ill. The other popular reasons were diseases and infections, lack of exercise and psychological stresses and conflicts. There is also a variety of other reasons listed.

5.8 ILLNESS BEHAVIOUR

The subjects were asked what they would normally do when they felt they were ill. Their responses appear in Table XXXVI. Significant differences (chi-squared) were found in the way the groups responded to help-seeking behaviour from a hospital, pharmacy, traditional healer, use of prayer, self medication or denial. The majority of patients indicated that they would see a doctor (81.5%). The Kwa Mashu Group differed significantly in their use of the hospital and pharmacy, self medicating and denial of their illness.The Hospital Group used prayer more often than the community Groups.

TABLE XXXVI
ILLNESS BEHAVIOUR OF SUBJECTS

Behaviour	Hospital n	%	Umlazi n	%	Kwa Mashu n	%	Total n	%
Go to a doctor	295	(78.5)	301	(83.1)	131	(85.1)	727	(81.5)
Go to a hospital	275	(73.1)	282	(77.9)	103	(66.9)	660	(74.0)**
Go to a pharmacy	145	(38.6)	153	(42.3)	86	(55.8)	384	(43.1)*
Pray	171	(45.5)	132	(36.5)	62	(40.3)	365	(41.0)**
Ask others for help	137	(36.4)	137	(37.8)	70	(45.5)	344	(38.6)
Ignore it	129	(34.3)	104	(28.7)	83	(53.9)	316	(35.4)*
Medicate yourself	101	(26.9)	92	(25.4)	99	(64.3)	292	(32.7)*
Go to someone for prayer	63	(16.8)	76	(21.0)	30	(19.5)	169	(19.0)
Read about it	31	(8.2)	68	(18.8)	17	(11.0)	116	(13.0)*
Go to a traditional healer	48	(12.8)	40	(11.0)	9	(5.8)	97	(10.9)

* p<0.01

** p<0.05

5.9 HEALTH AND ILLNESS BELIEFS

Cronbach's coefficient alpha test was done to establish the reliability of the HBQ. A reliability of 0.76 was obtained. A comparison of the groups on each item is presented below in Table XXXVII.

TABLE XXXVII
COMPARISONS OF GROUPS RESPONSES ON HBQ ITEMS (IN %)

	Hospital (N=376)	Umlazi (N=362)	Kwa Mashu (N=154)	Total (N=892)

1. People get sick because they are not strong.

Agree	48.4	37.9	21.4	39.46*
Sometimes agree	22.1	29.8	26.6	26.01
Disagree	22.6	28.4	37.7	27.58
Not sure	7.0	3.8	14.3	6.95

2. People get sick because they do not eat the proper foods.

Agree	57.2	47.5	48.7	51.85
Sometimes agree	33.8	43.4	37.0	38.27
Disagree	6.4	6.6	11.0	7.30
Not sure	2.7	2.5	2.6	2.58

3. Illness is due to desertion by God.

Agree	11.2	11.9	3.2	10.10*
Sometimes agree	21.0	26.2	12.3	21.66
Disagree	52.7	49.2	71.4	54.55
Not sure	15.2	12.4	13.0	13.69

4. Illness is caused by infection.

Agree	60.9	52.8	66.9	58.83**
Sometimes agree	27.4	32.6	24.7	29.13
Disagree	8.5	6.9	2.6	6.86
Not sure	3.2	6.9	5.8	5.17

5. Illness is caused by witchcraft or sorcery.

Agree	22.9	20.4	11.0	20.02**
Sometimes agree	30.3	22.9	33.1	28.05
Disagree	26.9	35.4	33.8	31.79
Not sure	20.0	19.9	20.8	20.14

6. People get sick because someone

has cursed or done something evil towards them.

Agree	16.8	11.0	11.0	13.48
Sometimes agree	19.9	26.0	24.7	23.26
Disagree	38.3	39.8	40.9	39.44
Not sure	25.0	22.9	22.7	23.82

7. People get sick because they do not exercise regularly.

Agree	36.2	36.5	32.5	35.69
Sometimes agree	34.3	35.9	46.1	37.04
Disagree	15.4	10.8	11.0	12.79
Not sure	14.1	16.6	10.4	14.48

8. Sickness 'comes' from the devil.

Agree	13.6	11.3	13.6	12.70
Sometimes agree	15.7	13.0	9.1	13.48
Disagree	45.2	50.3	50.0	48.20
Not sure	25.5	25.1	26.6	25.62

9. People go to doctors only when they are seriously ill.

Agree	42.3	35.1	38.3	38.76*
Sometimes agree	27.9	27.9	42.9	30.56
Disagree	14.9	14.1	13.6	14.38
Not sure	14.6	22.7	5.2	16.29

10.	Doctors are the only ones that can treat people who are ill.				
	Agree	20.2	9.1	13.0	14.53*
	Sometimes agree	22.3	19.9	9.7	19.26
	Disagree	40.2	45.6	68.8	47.52
	Not sure	17.3	24.6	7.8	18.69
11.	There is nothing a person can do to prevent themselves from getting ill.				
	Agree	19.9	12.7	18.2	16.74*
	Sometimes agree	25.0	23.5	10.4	21.91
	Disagree	40.4	41.2	59.7	44.16
	Not sure	14.6	22.1	11.7	17.19
12.	People get sick because they do not keep themselves clean.				
	Agree	34.0	30.1	39.6	33.56***
	Sometimes agree	37.5	40.3	44.2	39.98
	Disagree	16.5	13.5	11.0	14.41
	Not sure	12.0	14.9	5.2	12.05
13.	There are some illnesses that doctors cannot treat.				
	Agree	38.3	48.9	75.3	49.10*
	Sometimes agree	36.4	25.1	11.0	27.53
	Disagree	12.8	11.0	5.2	10.79
	Not sure	12.5	14.9	7.1	12.58
14.	People inherit illness from their parents.				
	Agree	25.3	29.8	16.9	25.79*
	Sometimes agree	42.6	42.5	64.9	46.62
	Disagree	18.4	14.4	9.1	15.20
	Not sure	13.9	13.0	7.8	12.39

15.	If a person takes good care of themselves they will not get sick.				
	Agree	31.4	27.3	31.2	29.94**
	Sometimes agree	34.3	35.1	39.6	35.82
	Disagree	19.9	17.1	21.4	19.21
	Not sure	14.4	19.3	5.8	15.03
16.	People are able to cure themselves when they are sick.				
	Agree	19.1	23.8	16.2	20.61***
	Sometimes agree	37.2	29.3	43.5	35.25
	Disagree	28.5	26.0	27.3	27.36
	Not sure	15.2	20.4	12.3	16.78
17.	If a person gets sick it is their own fault.				
	Agree	11.7	9.1	3.2	9.29*
	Sometimes agree	23.7	22.4	33.8	25.14
	Disagree	51.1	47.2	53.2	50.40
	Not sure	13.6	19.6	7.8	15.18
18.	Visiting a doctor for regular check ups can prevent a person getting sick.				
	Agree	42.8	29.8	38.3	36.98*
	Sometimes agree	29.8	31.5	40.3	32.47
	Disagree	14.4	15.2	10.4	14.09
	Not sure	13.0	22.4	10.4	16.46
19.	Doctors can make the illness better but they cannot treat the cause.				
	Agree	38.0	32.3	33.1	34.98***
	Sometimes agree	32.7	28.7	40.3	32.51
	Disagree	14.4	18.5	14.9	16.20
	Not sure	14.9	20.2	10.4	16.31

20.	Most illnesses can be treated at home.				
	Agree	26.9	22.9	21.4	24.49*
	Sometimes agree	31.6	34.0	19.5	30.70
	Disagree	23.1	22.9	41.6	26.41
	Not sure	18.4	19.3	15.6	18.40
21.	Older people know a lot about illness and can advice others what to do.				
	Agree	32.7	26.8	29.2	29.91**
	Sometimes agree	35.4	35.4	39.6	36.34
	Disagree	15.2	13.3	20.1	15.35
	Not sure	16.8	23.5	9.7	18.40
22.	People should pray to God to cure them of their illness.				
	Agree	27.4	23.5	37.7	27.64*
	Sometimes agree	29.5	25.1	39.0	29.44
	Disagree	23.4	25.4	14.3	22.70
	Not sure	19.7	25.7	8.4	20.22
23.	People get sick because they are lazy and do not work hard enough.				
	Agree	18.9	17.7	13.0	17.47**
	Sometimes agree	36.4	37.0	30.5	35.85
	Disagree	28.5	22.7	37.7	27.85
	Not sure	16.2	22.4	16.2	18.83
24.	When sick the treatment given by elders or older people can really be helpful.				
	Agree	17.8	20.4	13.0	18.17*
	Sometimes agree	37.2	36.2	37.0	37.02
	Disagree	23.1	14.4	31.8	21.22
	Not sure	21.8	28.2	16.9	23.59

25.	Illness is a form of punishment for the wrong or bad things a person has done.				
	Agree	13.0	10.5	7.8	11.17
	Sometimes agree	21.3	18.8	15.6	19.41
	Disagree	44.7	48.3	60.4	49.21
	Not sure	21.0	21.3	15.6	20.20
26.	People get sick when something foreign invades their body.				
	Agree	40.2	33.4	49.4	39.37**
	Sometimes agree	33.2	32.3	25.3	31.79
	Disagree	16.0	16.6	10.4	15.38
	Not sure	10.6	16.9	11.7	13.46
27.	Sickness occurs because you do not do the rituals or prayer required by the priest or ancestors.				
	Agree	15.4	11.3	5.2	12.04*
	Sometimes agree	26.1	15.5	16.9	20.25
	Disagree	37.8	42.3	59.7	43.53
	Not sure	20.8	30.7	17.5	24.18
28.	A person can become ill if they walk or cross over a path or spot where some ritual was performed.				
	Agree	24.2	25.4	11.0	22.57**
	Sometimes agree	33.2	27.1	33.1	30.93
	Disagree	22.6	24.3	32.5	25.17
	Not sure	20.0	22.4	22.1	21.33
29.	Sickness occurs because your body is not functioning properly.				
	Agree	33.0	29.6	50.0	34.76*
	Sometimes agree	35.6	37.6	33.1	36.23
	Disagree	18.9	19.6	5.8	17.04
	Not sure	12.5	12.4	9.1	11.96

30. Illness is due to demon. evil or bad spirit possession.				
Agree	14.9	9.9	9.7	12.06**
Sometimes agree	14.9	17.4	24.0	17.59
Disagree	51.9	48.3	39.0	48.48
Not sure	18.4	23.8	25.3	21.87
31. Illness is due to punishment or desertion by the ancestors				
Agree	15.8	16.3	7.1	14.53**
Sometimes agree	15.0	13.0	22.1	15.43
Disagree	49.5	44.2	48.1	47.18
Not sure	19.8	26.5	21.4	22.86

* $p<0.001$

** $p<0.01$

***$p<0.05$

The groups differed significantly on certain items. These items and the statistical significant values are presented below: item 1, between all 3 groups (χ^2=50.86, $p<0.001$); item 3, between the Hospital Group and Kwa Mashu Group (χ^2=19.16, $p<0.001$) and the Kwa Mashu Group and Umlazi Group (χ^2 = 27.69. $p<0.001$); item 4, all 3 groups (χ^2= 17.85, $p<0.01$); item 5, between all 3 groups (χ^2=17.93, $p<0.01$); item 9, between all 3 groups (χ^2=33.24, $p<0.001$); item 10, between all 3 groups (χ^2=61.59, $p<0.001$); item 11, between all 3 groups (χ^2=37.05, $p<0.001$); item 12, between the Hospital Group and Kwa Mashu Group (χ^2=9.37, $p<0.05$) and between the Kwa Mashu and Umlazi Group (χ^2=12.30, $p<0.01$); item 13, between all 3 groups (χ^2=68.92, $p<0.001$); item 14, between the Hospital Group and Kwa Mashu Group (χ^2=23.66, $p<0.001$) and the Kwa Mashu Group and Umlazi Group (χ^2=22.96, $p<0.001$); item 15, between the Kwa Mashu Group and Umlazi Group (χ^2=15.14, $p<0.01$); item 16, between the Hospital Group and Umlazi Group (χ^2=8.97, $p<0.05$) and between the Kwa Mashu Group and Umlazi Group (χ^2=13.37,

p<0.01); on item 17, between the Hospital Group and Kwa Mashu Group (χ^2=15.89, p<0.01) and the Kwa Mashu Group and Umlazi Group (χ^2=20.70, p<0.001); on item 18, between the Hospital Group and Umlazi Group (χ^2=17.92, p<0.001) and between the Kwa Mashu Group and Umlazi Group (χ^2=14.87, p<0.01); item 19, between Kwa Mashu Group and Umlazi Group (χ^2=11.30, p<0.01); item 20, between the Hospital Group and Kwa Mashu Group (χ^2=20.65, p<0.001) and the Kwa Mashu Group and Umlazi Groups (χ^2=21.85, p<0.001); item 21, between the Kwa Mashu Group and Umlazi Group (χ^2=14.63, p<0.01); item 22, between the Hospital Group and Kwa Mashu Group (χ^2=19.64, p<0.001) and the Kwa Mashu Group and Umlazi Group (χ^2=36.65, p<0.001); item 23, between the Kwa Mashu Group and Umlazi Group (χ^2=13.79, p<0.01); item 24, between the Hospital Group and Umlazi Group (χ^2=11.53, p<0.01) and the Kwa Mashu Group and Umlazi Group (χ^2=25.73, p<0.001); item 26, between the Kwa Mashu Group and Umlazi Group (χ^2=13.69, p<0.01); item 27, between all 3 groups (χ^2=44.67, p<0.001); item 28, between the Hospital Group and Kwa Mashu Group (χ^2=13.82, p<0.01) and the Kwa Mashu Group and Umlazi Group (χ^2=14.65, p<0.01); item 29, between the Hospital Group and Kwa Mashu Group (χ^2=22.09, p<0.001) and the Kwa Mashu Group and Umlazi Group (χ^2=27.63, p<0.001); item 30, between the Hospital Group and Kwa Mashu Group (χ^2=13.82, p<0.01) and, item 31, between Hospital Group and Kwa Mashu Group (χ^2= 14.09, p<0.01). The means and standard deviations of each item for the groups appear in Table XXXVIII

Item 1 assessed the belief that a person gets sick because they are not strong. On this item the Hospital Group agreed more than the community groups. Overall the respondents did 'agree' or 'sometimes agree' that if a person is not strong enough he will get sick. It seems that those who attend the hospitals have a stronger belief that those who are ill are not strong. There was some who disagreed with this view ranging from 22.6% in the Hospital Group to 37.7% in the community Group. There was general agreement by all groups that a person's diet may lead to illness (item 2). This is in keeping with reasons the subjects

offered why people get sick (Table XXXV). The subjects tended to disagree with the view that illness is due to desertion by God (item 3), especially those in the Kwa Mashu Group (71.4%). Although there is agreement that it sometimes could be true. The belief that illness is caused by infection was overwhelmingly endorsed by all subjects (item 4).

Item 5, which required the subjects to respond to the belief that illness was caused by witchcraft or sorcery yielded mixed responses. Half of the subjects either agreed or sometimes agreed or disagreed. Although the belief is not a dominant one it obviously is an important belief in interpreting and understanding their illnesses. In item 6 that deals with the belief that 'sickness is due to a curse or bewitchment by others, there were also mixed response. There is, however, a slightly higher tendency to disagree with such beliefs. There is a general belief among the subjects that lack of or inadequate regular exercise leads to ill health (item 7). Although small, there are some who disagree or are not sure of the benefits of regular exercise. Most subjects disagreed with the belief that sickness comes from the devil (item 8). On the average 25.62% where not sure. A similar percentage agreed or sometimes agreed.

The consulting of doctors as the only help-seeking behaviour when seriously ill (item 9) was a dominant health seeking behaviour. Yet most of the subjects disagreed with the belief that only doctors can treat people who are ill (item 10), this being more so in the community Groups than the Hospital Group. Of those who agreed with this belief, the Hospital Group showed greater agreement. On item 11, which assessed the belief that there is nothing a person can do to prevent illness, a large number disagreed; 16.74% agreed, 21.91 % sometimes agreed and 17.19% were not sure. This may indicate that there is a belief in an internal locus of control in the prevention of illness. Sickness as a result of poor self care and/or hygiene was endorsed by most of the subjects (item 12).

The interviewees agreed or sometimes agreed that some illness cannot be treated by medical doctors (item 13). This would suggest then that if individuals do not believe that doctors can treat all illnesses they would seek help from other sources and persons they

felt would provide appropriate treatment. Subjects also endorsed the belief that sometimes illnesses are inherited (item 14).

On item 15, subjects endorsed the belief that taking care of oneself can prevent illnesses.19,21% disagreed and 15.03% were not sure. Again, the issue of internal locus of control in health behaviour must be considered. The subjects felt that they were able to effect a cure themselves when ill (item 16); 27.36% disagreed and 16.78% were not sure. However, they did not see any reason to blame themselves for the illness (item 17). Only in a few instances did they agree that their illness could be their fault.

'Visiting a doctor for regular check ups can prevent a person getting sick' was agreed or sometimes agreed by most respondents (item 18). However, 14.09% disagreed and 16.46% were not sure. In addition, subjects expressed the belief that doctors can treat symptoms but not the cause (item 19).

There was a generalised response to the belief that most illnesses can be treated at home (item 20); 24.49% agreed, 30.70% agreed sometimes, 26.41% disagreed and 18.40% were not sure. Respondents also believed that older people know a lot about illnesses and that they can provide appropriate advice (item 21); 29.91% agreed and 30.70% sometimes agreed.

Item 22 dealt with the belief that people should pray to God to cure them of their illness. The response varied from 27.64% agreeing, 29.44% agreeing sometimes, 22.70% disagreeing and 20.22% not being sure. Item 23 looked at the belief that people get sick because they are lazy and do not work hard enough. Most of the subjects sometimes agreed (35.85%).

Beliefs about the treatment given by elders or older people was assessed by item 24. The most common response was 'sometimes agree' (37.02%). The second highest response was not sure (23.59%); 18.17% agreed and 21.22% disagreed.

As much as 49.21% of the subjects disagreed with the belief that illness is a form of punishment for the wrong or bad things that a person as done (item 25). However, 19.41% agreed sometimes, 11.17% agreed and 20.20% were not sure.

The belief that a person gets sick as a result of something invading their body (item 26) was a widely accepted belief by subjects either agreeing (39.37%) or sometimes agreeing (31.79%). Only 13,46% were not sure and 15.38% disagreed with the statement. The Kwa Mashu subjects showed the highest agreement with the statement (49.4%) and lowest disagreement (10.4%). Item 27 assessed the belief that sickness occurred as a result of not performing the required rituals or prayers to the ancestors. Although 43.53 % disagreed with this belief, 12.04% agreed, 20.25% agreed sometimes and 24.18 were not sure. The Kwa Mashu subjects demonstrated the least agreement with the statement (5.2%) and highest disagreement (59.7%). A varied response was obtained for the belief that people can become ill if they walk or cross over a path or place where some ritual was performed (item 28). The response 'sometimes agree' was the most common (22.57%), while 22.57% agreed and 21.33% were not sure. 25.17% disagreed with the belief. The Kwa Mashu Group demonstrated the lowest agreement with this belief.

The belief that sickness is the result of malfunctioning or improper function of the body (item 29) appears to be a common belief of the respondents; 34.76% agreed and 36.23% sometimes agreed. The Kwa Mashu subjects showed a high agreement with the statement (50.0%) and the lowest disagreement (5.8%)

There was a high disagreement with statement 30 that illness is due to demon, evil or bad spirit possession (48.48%). Both the community Groups showed low agreement; Umlazi 9.9% and Kwa Mashu 9.7%. The Hospital Group demonstrated more agreement with the belief (14.9%). However, the Hospital Group also responded with the highest disagreement (51.9%).

The last item assessed the belief that illness is due to punishment or desertion by the ancestors. The respondents showed high disagreement with this belief (47.18%).

Although, 22.86% were not sure, 14.53% agreed and 15.43% sometimes agreed with the belief. The Kwa Mashu Group indicated a low agreement with this belief.

TABLE XXXVIII
MEANS AND STANDARD DEVIATIONS OF EACH HBQ ITEM FOR GROUP

Item No.	Hospital Mean	Hospital SD	Umlazi Mean	Umlazi SD	Kwa Mashu Mean	Kwa Mashu SD
1	1.88	0.99	1.98	0.91	2.45	0.98*
2	1.55	0.73	1.64	0.72	1.67	0.78
3	2.72	0.85	2.62	0.85	2.94	0.62*
4	1.54	0.78	1.68	0.88	1.47	0.81**
5	2.43	1.05	2.55	1.03	2.65	0.94**
6	2.72	1.02	2.75	0.93	2.76	0.93
7	2.07	1.04	2.07	1.07	1.99	0.93
8	2.83	0.96	2.89	0.91	2.90	0.95
9	2.02	1.08	2.24	1.16	1.86	0.84*
10	2.55	1.00	2.86	0.89	2.72	0.79*
11	2.50	0.97	2.73	0.95	2.65	0.91*
12	2.06	0.99	2.13	1.01	1.82	0.82***
13	1.99	1.01	1.92	1.09	1.43	0.89*
14	2.20	0.97	2.11	0.98	2.08	0.76*
15	2.17	1.03	2.29	1.07	2.02	0.88**
16	2.39	0.96	2.43	1.07	2.36	0.90***
17	2.66	0.85	2.79	0.87	2.67	0.67*
18	1.98	1.05	2.30	1.13	1.93	0.95*
19	2.06	1.06	2.27	1.12	2.03	0.96***
20	2.33	1.06	2.39	1.05	2.52	1.01*
21	2.16	1.06	2.34	1.12	2.11	0.94**
22	2.35	1.08	2.53	1.11	1.93	0.93*
23	2.42	0.97	2.50	1.03	2.59	0.92**
24	2.49	1.02	2.51	1.11	2.53	0.93*
25	2.73	0.94	2.81	0.89	2.84	0.78
26	1.97	0.99	2.17	1.08	1.84	1.04**
27	2.63	0.98	2.93	0.96	2.98	0.74*
28	2.38	1.06	2.44	1.10	2.66	0.95**
29	2.11	1.00	2.15	0.99	1.74	0.94*
30	2.74	0.93	2.86	0.89	2.81	0.93**
31	2.73	0.95	2.81	1.01	2.85	0.84**

* p<0.001

** p<0.01

*** p<0.05

A factor analysis with varimax rotation (SAS package) of the items was done. Nine factors where retained according to the Mineigen criterion. Items with loading of 0.35 or more were included in each factor. The factor analysis revealed nine factors with eigenvalues >1. The results of the factor analysis appear in Table XXXIX.

TABLE XXXIX
FACTOR ANALYSIS OF THE HBQ (COMBINED)

	Items	Loading*	Eigen-value	Vari-ance %
Factor 1			4.33	3.06
31.	Illness is due to punishment or desertion by the ancestors	0.81		
30.	Illness is due to demon, evil or bad spirit possession	0.75		
6.	People get sick because someone as cursed or done something evil towards them	0.63		
25.	Illness is a form of punishment for the wrong or bad things a person has done	0.54		
5.	Illness is caused by witchcraft or sorcery	0.53		
27.	Sickness occurs because you do not do the rituals or prayers required by the priest or ancestors	0.53		
28.	A person can become ill if they walk or cross over a path or spot where some ritual was performed	0.46		
8.	Sickness 'comes' from the devil	0.43		
Factor 2			3.27	2.41
3.	Illness is due to desertion by God	0.74		

1.	People get sick because they are not strong		0.60		
17.	If a person gets sick it is their own fault		0.56		
Factor 3				1.94	2.08
2.	People get sick because they do not eat the proper foods		0.68		
4.	Illness is caused by infection	0.50			
12.	People get sick because they do not keep themselves clean		0.46		
14.	People inherit illnesses from their parents		0.43		
Factor 4				1.51	2.01
20.	Most illnesses can be treated at home		0.71		
24.	When sick, the treatment given by elders or older people can really be helpful	0.64			
21.	Older people know a lot about illness and can advise others what to do		0.63		
16.	People are able to cure themselves when they are sick		0.49		
Factor 5				1.25	1.84
29.	Sickness occurs because your body is not functioning properly		0.66		
23.	People get sick because they are lazy and do not work hard enough		0.58		
7.	People get sick because they do not exercise regularly		0.58		
26.	People get sick when something foreign invades their body		0.50		
Factor 6				1.18	1.46
10.	Doctors are the only ones who can treat people who are ill		0.70		
11.	There is nothing a person can do to prevent themselves from getting ill	0.61			
9.	People go to doctors only when they are seriously ill		0.41		

Factor 7		1.15	1.45
18. Visiting a doctor for regular check ups can prevent a person getting sick	0.79		
15. If a person takes good care of themselves they will not get sick	0.60		
Factor 8		1.07	1.24
22. People should pray to God to cure them of their illness	0.68		
Factor 9		1.01	1.19
19. Doctors can make the illness better but they cannot treat the cause	0.80		

* Items with loadings of 0.35 or more on a factor were retained.

The nine factors which emerged could be described as follows:

Factor 1: External evil or ancestral influence - cultural (aetiology)

The items that loaded on this factor suggest that the aetiology of illness is the result of 'punishment or desertion by the ancestors'; 'demon, evil or bad spirit possession'; 'because someone has cursed or done something evil towards another'; 'form of punishment for the wrong or bad things a person has done' 'witchcraft or sorcery'; 'do not do the rituals or prayer required by the priest or ancestors'; 'they walk or cross over a path or spot where some ritual was performed'; 'comes from the devil'.

Factor 2: Self blame (aetiology)

The items that loaded on this factor supports the aetiology of illness as a result of the individual not being strong enough. Illness is due to desertion by God; because people are not strong; or it is the individual's fault.

Factor 3: Medical reason (aetiology)

The items that loaded on this factor suggest that people get sick because they do not eat the proper foods; illness is caused by infection; people get sick because they do not keep themselves clean; people inherit illnesses from their parents.

Factor 4: Self medication (treatment)

This factor deals with treatment. The items that loaded here suggest that most illnesses can be treated at home; treatment given by elders or older people can really be helpful; older people know a lot about illness and can advise others what to do and people are able to cure themselves when they are sick.

Factor 5: Physical weakness or body malfunctioning (aetiology)

This factor suggests that sickness occurs because the body is not functioning properly; people get sick because they are lazy and do not work hard enough; or they do not exercise regularly or people get sick when something foreign invades their body.

Factor 6: Medical (treatment)

The items that loaded on this factor supports the view that doctors are the only ones who can treat people who are ill, that there is nothing a person can do to prevent themselves from getting ill and that people go to doctors only when they are seriously ill.

Factor 7: Self care (prevention)

This factor represents items that involve self care as a preventative measure against illness. The items that loaded on this factor included visiting a doctor for regular check ups to prevent a person getting sick; if a person takes good care of themselves they will not get sick;

Factor 8: Use of prayer (treatment)

The item that loaded on this factor 'people should pray to God to cure them of their illness' suggest prayer and the evoking of God's assistance as a method of treatment.

Factor 9: Holistic belief (treatment)

This factor suggest that the medical model is only partly effective as a treatment. The item loading on this factor 'doctors can make the illness better but they cannot treat the cause' suggest additional methods to the medical model.

Factor scores were calculated for each of the nine factors by adding the values on each item. A multivariate analysis (MANOVA) was performed on the nine factors with main

effects: group, sex and urbanisation (0-5 years and >5 years). Age was used as a covariate. The factor scores for each factor is found in Table XL.

TABLE XL
MEAN FACTOR SCORES ON THE NINE FACTORS RELATING TO HEALTH BELIEF

Factor	Hospital		Umlazi		Kwa Mashu	
	Mean	SD	Mean	SD	Mean	SD
1	17.83	4.31	18.99	3.86	19.37	4.23
2	8.55	1.80	8.45	1.67	8.77	1.25
3	6.65	1.69	6.69	1.85	6.46	1.53
4	7.90	1.95	7.82	1.92	8.36	2.29
5	7.31	2.03	7.12	1.86	7.00	1.81
6	6.17	1.62	6.61	1.32	6.82	1.44
7	3.52	1.22	3.79	1.08	3.57	1.22
8	1.95	0.80	2.03	0.82	1.74	0.72
9	1.72	0.73	1.83	0.78	1.79	0.71

On factor 1 no main effects or interactions were found.

On Factor 2 there was significant differences between living in an urban area for 0-5 years and >5 years.($F(1, 885)=13.59$, $p=0.0003$). On Factor 3 the analysis revealed significant differences in the group by urban interaction ($p=0.0179$), and significance with effect on age ($p=0.0015$). Significant differences between the Hospital, Umlazi and Kwa Mashu Groups ($p=0.0220$), urban ($p=0.0355$), group by urban interaction ($p=0.0031$) were found on factor 4.

On factor 5 significant differences were found between groups ($p=0.0012$), groups by urban interaction ($p=0.0003$) and age ($p=0.0483$)

For factor 6 significant differences were found between groups ($p=0.0370$) and between groups by interaction ($p=0.0370$).

Significant differences was found on factor 7 depending on the number of years patients were living in an urban area(p=0.0165), in group by sex (p=0.0407) and in group by living in urban areas (p=0.0250).
On factor 8 the significant differences were between groups (p=0.0146) and between group by urban dwelling (p=0.0137).

On factor 9 significant differences were found in group by urban dwelling (p=0.0423) and age (p=0.0106).

5.10 SOCIAL SUPPORT

The reliability of the SSQ was determined by subjecting it to the Cronbach's alpha test. A Cronbach's coefficient alpha of 0.91 was obtained. Table XLI lists the percentage of responses on each item. It would appear from the responses that the subjects in all groups were generally satisfied with the social support they received and perceived themselves as a source of support as well.

TABLE XLI
COMPARISONS OF SSQ ITEMS BETWEEN GROUPS (in %)

	Hospital (N=368)	Umlazi (N=360)	Kwa Mashu (N=152)	Combined (N=880)
1. Who can you really count on to listen to you when you need to talk?				
Very satisfied 60.05	53.31	64.24	58.00	
Satisfied 39.13	46.69	35.10	41.54	
Dissatisfied 0.82	0.00	0.00	0.34	
Very dissatisfied 0.00	0.00	0.66	0.11	
2. Who could you really count on to help you in an emergency or crisis situation.				
Very satisfied 52.72	52.50	57.89	53.52	
Satisfied 46.26	46.94	40.79	45.57	
Dissatisfied 0.82	0.28	1.32	0.68	
Very dissatisfied 0.27	0.28	0.00	0.23	
3. Who helps you feel that you are a good and worthwhile person?				
Very satisfied 55.59	52.22	51.66	53.53	
Satisfied 42.78	46.39	45.70	44.76	
Dissatisfied 1.09	0.83	0.66	0.91	
Very dissatisfied 0.54	0.56	1.99	0.80	

4. Whom can you really go to when you are worried and/ or under pressure?

Very satisfied	53.53	52.91	42.38	51.36
Satisfied	44.57	46.26	56.95	47.36
Dissatisfied	1.63	0.55	0.66	1.02
Very dissatisfied		0.27	0.28	0.00	0.23

5. Who can you count on when you generally need help for reasons other than an emergency or crisis?

Very satisfied	48.50	49.58	41.72	47.78
Satisfied	50.14	49.58	54.97	50.74
Dissatisfied	1.36	0.83	2.65	1.37
Very dissatisfied		0.00	0.00	0.66	0.11

6. Who can you really count on to help you if things go wrong, you have a mishap or run out of luck? (eg. fired from your job, meet an accident, etc.)

Very satisfied	50.95	49.58	47.37	49.77
Satisfied	47.97	50.15	48.68	48.97
Dissatisfied	0.81	0.28	3.95	1.13
Very dissatisfied		0.27	0.00	0.00	0.11

7. Who can you really count on to give you useful advice, guidance or suggestions that help you to avoid making mistakes?

Very satisfied	48.91	48.20	49.34	48.69
Satisfied	49.46	50.42	49.34	49.83
Dissatisfied	1.36	1.39	1.32	1.36
Very dissatisfied		0.27	0.00	0.00	0.11

8. Who do you feel would help if a family member

	or someone very close to you died?				
	Very satisfied	45.11	49.72	42.00	46.47
	Satisfied 53.26	47.78	54.67	51.25	
	Dissatisfied 1.36	2.22	2.67	1.94	
	Very dissatisfied	0.27	0.28	0.67	0.34
9.	Who do you feel truly loves you deeply?				
	Very satisfied	55.83	57.50	70.20	58.98
	Satisfied 43.09	41.94	29.80	40.34	
	Dissatisfied 0.54	0.28	0.00	0.34	
	Very dissatisfied	0.54	0.28	0.00	0.34
10.	Who can you count on to comfort/ console you when you are very upset?				
	Very satisfied	46.17	48.88	53.33	48.51
	Satisfied 51.91	50.84	46.00	50.46	
	Dissatisfied 1.64	0.28	0.67	0.92	
	Very dissatisfied	0.27	0.00	0.00	0.11
11.	Who can you really count on to support you in major decisions or plans you make?				
	Very satisfied	50.68	44.60	52.00	48.41
	Satisfied 48.23	54.29	47.33	50.57	
	Dissatisfied 1.09	1.11	0.00	0.91	
	Very dissatisfied	0.00	0.00	0.67	0.11

12. Who do you know whom you can trust with a secret or information that could get you in trouble?

Very satisfied	49.86	45.98	50.34	48.34
Satisfied	48.77	52.91	46.26	50.06	
Dissatisfied	0.82	0.83	2.72	1.14
Very dissatisfied	0.54	0.28	0.68	0.46

13. Who do you count on when you are ill?

Very satisfied	49.05	40.28	57.33	46.87
Satisfied	49.05	58.89	41.33	51.76	
Dissatisfied	1.63	0.56	0.67	1.02	
Very dissatisfied	0.27	0.28	0.67	0.34

14. Who can you really count on when you get into trouble?

Very satisfied	48.91	42.46	54.05	47.13
Satisfied	50.55	55.87	45.95	51.95	
Dissatisfied	0.55	1.40	0.00	0.80	
Very dissatisfied	0.00	0.28	0.00	0.11

15. Who do you think will come to you if they had a need or problem?

Very satisfied	57.14	48.19	45.27	51.44
Satisfied	41.76	50.97	52.70	47.42	
Dissatisfied	1.10	0.56	1.35	0.92	
Very dissatisfied	0.00	0.28	0.68	0.23

The means and standard deviations of the subjects' responses for each item on the SSQ are presented in Table XLIV.

TABLE XLII
MEANS AND STANDARD DEVIATIONS OF SSQ ITEMS BY GROUPS

Item No.	Hospital Mean	Hospital SD	Umlazi Mean	Umlazi SD	Kwa Mashu Mean	Kwa Mashu SD
1.	3.59	0.51	3.53	0.50	3.63	0.52
2.	3.51	0.53	3.52	0.52	3.57	0.52
3.	3.53	0.55	3.50	0.55	3.47	0.62
4.	3.51	0.55	3.52	0.53	3.42	0.51
5.	3.47	0.53	3.49	0.52	3.38	0.57
6.	3.50	0.53	3.49	0.51	3.43	0.57
7.	3.47	0.54	3.47	0.53	3.48	0.53
8.	3.43	0.54	3.47	0.56	3.38	0.58
9.	3.54	0.54	3.57	0.52	3.70	0.46
10.	3.44	0.54	3.49	0.51	3.53	0.51
11.	3.50	0.52	3.43	0.52	3.52	0.54
12.	3.48	0.55	3.45	0.53	3.46	0.59
13.	3.47	0.55	3.39	0.52	3.55	0.55
14.	3.48	0.51	3.41	0.54	3.54	0.50
15.	3.56	0.51	3.47	0.53	3.43	0.56

5.10.1 Comparisons of groups on accessibility and proximity

Analysis of variance was performed on the variables accessibility (immediate and delayed) and proximity (nearby and far). Significant differences were found between the three groups on all these variables (Table XLII).

TABLE XLIII
ANOVA OF ACCESSIBILITY AND PROXIMITY

	df	F	p

Accessibility:			
Immediate	2	98.72	p<0.0001*
Delayed	2	71.07	p<0.0001**
Proximity:			
Nearby	2	110.30	p<0.0001*
Far	2	67.08	p<0.0001**

Duncan's Multiple Range Test was performed as a post hoc test for pairwise comparisons. The results are found in Table XLIII.

The mode in which the subjects obtained their support was as follows: Hospital Group (N=376), 304 (80.85%) used the telephone and 123 (32.71%) wrote; Umlazi Group (N=362), 20 (5.52%) used the telephone and 100 (27.62%) wrote; with the Kwa Mashu Group (N=154), 147 (95.45%) telephoned and 92 (59.74%) wrote. Both the Hospital and the Kwa Mashu Groups used the telephone as the main means of communication and for obtaining social support. The other way was by postal service.

A factor analysis of the subjects' responses on the fifteen items on the SSQ was done. The rotational varimax method was used and two factors emerged (Table XLV).

TABLE XLIV
DUNCAN'S MULTIPLE RANGE TEST

Duncan's Grouping	Mean	N	Group

Accessibility (immediate)				
	A	3.43	154	Kwa Mashu
	B	2.03	362	Umlazi
	C	1.75	376	Hospital
Accessibility (delayed)				
	A	1.66	154	Kwa Mashu
	B	0.69	362	Umlazi
	B	0.62	376	Hospital
Proximity (Nearby)				
	A	3.40	154	Kwa Mashu
	B	2.00	362	Umlazi
	C	1.64	376	Hospital
Proximity (Far)				
	A	1.71	154	Kwa Mashu
	B	0.70	362	Umlazi
	B	0.70	376	Hospital

The subjects reported obtaining social support from mainly family and friends. The family support was as follows: mother (27,78%), spouse (22.53%), friend (7.80%), brother (7.17%), father (6.59%), sister (5.38%), children (4.16%) and priest/minister (1.34). No subject reported father support on item 10 - 'Who can you count on to comfort or console you when you are very upset?'

TABLE XLV
FACTOR ANALYSIS OF THE SSQ (COMBINED)

	Items	Loading*	Eigen-value	Vari ance %
Factor 1			6.74	4.21
2.	Who could you really count on to help you in an emergency or crisis situation?	0.72		
4.	Who can you really go to when you are worried and/or under pressure?	0.72		
5.	Who can you count on when you generally need help for reasons other than an emergency or crisis?	0.72		
6.	Who can you really count on to help you if things go wrong, you have a mishap or run out of luck? (eg. fired from your job, meet an accident, etc.)	0.71		
3.	Who helps you feel that you are a good and worthwhile person?	0.70		
1.	Who can you really count on to listen to you when you need to talk?	0.65		
7.	Who can you really count on to give you useful advice, guidance or suggestions that help you to avoid making mistakes?	0.63		
8.	Who do you feel would help if a family member or someone very close to you died?	0.54		
Factor 2			1.37	3.90
13.	Who do you count on when you are ill?	0.78		
14.	Who can you really count on when you get into trouble?	0.75		
15.	Who do you think will come to you if they had a need or problem?	0.72		
12.	Who do you know whom you can trust with a secret or information that could get you in trouble?	0.71		
11.	Who can you really count on to support you in major decisions or plans you make?	0.69		
10.	Who can you count on to comfort/ console you when you are very upset?	0.59		
9.	Who do you feel truly loves you deeply?	0.56		

* Items with loadings of 0.35 or more on a factor were retained

Factor 1

The items that loaded high on this factor deals with support in an emergency or crisis situation; when you are worried and/or under pressure; need help for reasons other than an emergency or crisis; help you if things go wrong, you have a mishap or run out of luck? (eg. fired from your job, meet an accident, etc.); helps you feel that you are a good and worthwhile person; to listen to you when you need to talk; to give you useful advice, guidance or suggestions that help you to avoid making mistakes; help if a family member or someone very close to you died.

Factor 2

The items that loaded high on this factor deals with support when ill; when you get into trouble; if they had a need or problem; can trust with a secret or information that could get you in trouble; in major decisions or plans you make; to comfort/ console you when you are very upset'; who you feel truly loves you deeply.

Factor scores for each of the factors on the social support questionnaire were calculated by adding the values for each item on the factor. A 3-way Multivariate Analysis of Variance (MANOVA) was performed on the two factors to determine whether there were differences between the 3 groups (Hospital, Umlazi and Kwa Mashu), between males and females and between living in an urban area for 0-5 years and >5 years. (The MANOVA tests for within subject effects and related interactions). The actual age was used as a covariate in the analysis.

The overall F tests yielded significant effects for both Factor 1 ($F=2.08$, $p<0.0162$) and Factor 2 ($F=1.83$, $p<0.0404$).

On Factor 1 the main effects (group, sex and urban dwelling) showed no significant results. However there were significant interactions between group by sex ($p=0.0072$), group by urban dwelling ($p=0.0178$) and sex by urban dwelling ($p=0.0289$). See Table XLVI.

TABLE XLVI
MANOVA ON FACTOR 1 OF SSQ

	df	SD	F	p
Group	2	31.06	1.64	0.1940
Sex	1	27.49	2.91	0.0885
Urban	1	3.76	0.40	0.5284
Group by sex	2	93.86	4.97	0.0072*
Group by urban	2	76.54	4.05	0.0178**
Sex by urban	1	5.27	4.79	0.0289**
Group by sex by urban	2	34.30	1.81	0.1636
Age	1	57.92	6.13	0.0135**

* $p < 0.01$

* $p < 0.05$

A significant group by sex interaction meant that the males and the females in the 3 groups responded differently to factor 1. Age also had a significant effect on the factor (p=0.0135).

Table XLVII shows the significant interactions on factor 2 between group and sex (p=0.0465) and group by urban dwelling (p=0.0160).

TABLE XLVII
MANOVA ON FACTOR 2 OF SSQ

	df	SD	F	p
Group	2	16.59	1.11	0.3291
Sex	1	17.68	2.37	0.1238
Urban	1	20.43	2.74	0.0981
Group by sex	2	45.89	3.08	0.0465*
Group by urban	2	61.98	4.16	0.0160*
Sex by urban	1	5.50	0.74	0.3905
Group by sex by urban	2	10.66	0.72	0.0894
Age	1	1.23	0.17	0.6846

* $p < 0.05$

It is also apparent from the MANOVA that there is a good correlation between Factor 1 and Factor 2 ($r = 0.670$).

5.11 SYMPTOM PERCEPTIONS

Reliability was determined using the Cronbach's coefficient alpha test. A high reliability of 0.96 was achieved. The percentage of subjects in each group who had experienced the symptoms in the modified symptom inventory is found in Table XLVIII.

TABLE XLVIII
EXPERIENCE OF SYMPTOMS BY EACH SUBJECT BY GROUP

	Symptom	Hospital	Umlazi	Kwa Mashu	Total
1	Headaches	93.86	92.07	93.42	93.12
2	Nervousness or shakiness inside	53.98	47.59	66.45	56.01
3	Being unable to get rid of bad thoughts or ideas	31.52	29.12	36.49	32.38
4	Faintness or dizziness	59.93	43.05	65.33	56.10
5	Loss of sexual interest or pleasure	25.45	20.28	42.28	29.34
6	Feeling critical of others	29.09	40.00	27.63	32.24
7	Bad dreams	65.34	58.13	68.21	63.89
8	Difficulty in speaking when you are excited	50.54	55.52	48.00	51.35
9	Trouble remembering things	48.55	45.33	52.32	48.73
10	Worried about sloppiness or carelessness	48.73	50.35	51.66	50.25
11	Feeling easily annoyed or irritated	56.52	51.22	63.58	57.12
12	Pains in the heart or chest	40.43	32.17	44.08	38.89
13	Itching	48.55	44.95	81.21	58.24
14	Feeling low in energy or slowed down	56.36	57.04	78.15	63.85
15	Thoughts of ending your life	18.84	30.66	11.84	20.44
16	Sweating	71.38	65.97	68.87	68.74
17	Trembling	42.55	37.98	27.81	36.11
18	Feeling confused	50.36	42.86	51.32	48.18
19	Poor appetite	61.96	63.88	63.58	63.14
20	Crying easily	35.87	37.63	26.67	33.39
21	Feeling shy or uneasy with the opposite sex	37.09	35.44	31.58	34.70
22	A feeling of being trapped or caught	25.82	32.40	18.42	25.55
23	Suddenly afraid for no reason	34.55	35.89	33.55	34.66
24	Temper outburst you could not control	49.82	50.17	46.71	48.90
25	Constipation	52.73	59.16	79.47	63.79
26	Blaming yourself for things	50.18	54.86	64.00	56.35
27	Pains in the lower part of your back	52.19	49.13	54.00	51.77

28	Feeling blocked or stymied in getting things done	35.79	35.44	42.3837.87	
29	Feeling lonely	46.91	50.69	72.3756.66	
30	Feeling blue	40.22	47.06	59.87	49.05
31	Worrying or stewing about things	48.00	54.33	74.17	58.83
32	Feeling no interest in things	42.34	38.19	58.94	46.49
33	Feeling fearful	38.77	41.96	47.3342.69	
34	Your feelings being easily hurt	41.82	44.10	51.32	45.75
35	Having to ask others what you should do	51.83	51.21	54.61	52.55
36	Feeling others do not understand	38.69	47.74	49.01	45.15
37	Feeling that people are unfriendly or dislike you	34.07	48.59	43.71	42.12
38	Having to do things very slowly in order to be sure you are doing them right	57.86	59.52	61.18	59.52
39	Heart pounding or racing	44.77	33.80	43.71	40.76
40	Nausea or upset stomach	53.99	54.17	72.85	60.34
41	Feeling inferior to others	41.30	56.40	36.18	44.63
42	Soreness of your muscles	45.29	43.94	63.16	50.80
43	Loose bowel movements	63.64	76.82	72.37	70.94
44	Difficulty in falling asleep or staying asleep	50.91	43.94	74.83	56.56
45	Having to check and double check what you do	58.39	55.71	75.66	63.25
46	Difficulty making decisions	40.88	36.81	60.26	45.98
47	Wanting to be alone	48.18	38.06	52.63	46.29
48	Trouble getting your breath	33.45	31.25	26.00	28.23
49	Hot or cold spells	45.99	40.21	59.73	48.64
50	Having to avoid certain places or activities because they frighten you	36.86	42.01	46.26	41.71
51	Your mind going blank	24.54	28.13	19.21	23.96
52	Numbness or tingling in parts of your body	26.37	24.13	23.65	24.72
53	A lump in your throat	29.20	29.72	38.6732.53	
54	Feeling hopeless about the future	35.40	33.33	41.33	36.69
55	Trouble concentrating	32.12	32.64	37.75	34.17
56	Weakness in parts of your body	35.77	25.00	20.95	27.24
57	Feeling tense or keyed up	30.40	29.51	28.67	29.53
58	Heavy feelings in your				

	arms or legs	33.94	29.51	27.52	30.32
Additional items					
59	Fever	79.93	79.44	88.74	82.70
60	Chills	64.47	70.48	75.66	70.20
61	Sore throat	63.50	69.90	82.00	71.80
62	Aches and pains all over	62.41	59.16	70.39	63.99
63	Sneezing	66.42	59.93	86.75	71.03
64	Runny nose	51.27	43.55	67.32	54.05
65	Stomach pain	56.93	47.06	73.33	59.12
66	Swelling	34.18	24.31	26.67	28.39
67	Hair loss	21.82	36.24	27.15	28,40
68	Pain during urination	30.55	29.51	40.6733.58	
69	Skin rash	42.70	41.96	58.94	47.87
70	Coughing	66.18	61.94	80.00	69.37
71	Blurred vision	32.36	42.51	30.2635.04	
72	Slurred speech	20.36	25.69	18.54	21.53
73	Vomiting	31.64	32.29	48.67	37.53
74	Blood in stool	17.45	20.07	17.4518.32	
75	Coughing blood	21.09	19.10	9.21	16.47
76	Burning sensations all over or in certain parts of the body	36.36	35.79	23.49	31.88
77	Loss of weight	41.82	52.26	44.0846.05	
78	Swollen glands	21.45	23.26	15.13	19.95
79	Night sweats	46.91	39.58	36.18	40.89
80	Bleeding	20.07	26.65	24.83	23.85
81	Discharge from ear, nose or eyes	14.18	18.53	15.44	16.05
82	Vaginal or penile discharge	17.88	20.83	34.23	24.31
83	Blood in urine	11.31	16.96	15.5414.60	

5.12 SUBJECTS RATING OF SEVERITY OF SYMPTOMS

Table XLIX presents the mean and standard deviations of the subjects rating of severity of symptoms. The severity of the symptoms were rated as follows: not serious = 1; serious = 2 and very serious = 3. The mean score for each item indicates that the items were rated as being either serious or very serious by the subjects.

TABLE XLIX
MEAN AND STANDARD DEVIATION OF SEVERITY OF SYMPTOMS

Item No.	Hospital Mean	Hospital SD	Umlazi Mean	Umlazi SD	Kwa Mashu Mean	Kwa Mashu SD
1.	2.87	0.83	2.63	0.72	2.63	0.77
2.	2.34	0.87	2.05	0.82	2.45	0.93
3.	2.07	0.05	1.96	0.88	2.36	0.91
4.	2.36	0.89	2.04	0.89	2.54	0.84
5.	2.04	0.87	1.87	0.89	2.74	1.03
6.	2.09	0.81	2.21	0.97	2.17	0.84
7.	2.50	0.87	2.41	0.92	2.55	0.78
8.	2.29	0.84	2.34	0.99	2.49	0.85
9.	2.25	0.87	2.05	0.85	2.65	0.88
10.	2.35	0.93	2.35	1.01	2.46	0.82
11.	2.39	0.86	2.47	1.01	2.57	0.82
12.	2.19	0.88	1.99	0.89	2.52	0.82
13.	2.22	0.88	2.02	0.83	2.37	0.74
14.	2.36	0.92	2.21	0.83	2.21	0.62
15.	1.99	0.84	1.98	0.93	2.99	1.15
16.	2.50	0.92	2.14	0.76	2.26	0.67
17.	2.26	0.93	1.97	0.84	2.38	0.85
18.	2.28	0.94	2.06	0.90	2.59	0.90
19.	2.39	0.95	2.35	0.92	2.36	0.74
20.	2.15	0.94	2.12	0.99	2.24	0.82
21.	2.04	0.92	1.93	0.93	2.40	0.81
22.	1.96	0.86	1.87	0.94	2.41	0.94
23.	1.97	0.93	2.03	1.02	2.59	0.94
24.	2.18	1.04	2.43	1.09	2.69	0.90
25.	2.08	0.93	2.23	0.93	2.49	0.79
26.	2.15	0.99	2.23	1.03	2.53	0.86
27.	2.18	1.04	2.21	1.03	2.56	0.84
28.	2.03	0.99	1.80	0.82	2.59	0.94

29.	**2.12**	**0.98**	**2.15**	**1.03**	**2.43**	**0.83**
30.	**2.08**	**1.02**	**2.01**	**1.01**	**2.33**	**0.85**
31.	**2.15**	**1.01**	**2.13**	**1.05**	**2.66**	**0.80**
32.	**2.05**	**0.96**	**1.90**	**0.97**	**2.49**	**0.86**
33.	**2.06**	**0.99**	**2.02**	**1.02**	**2.62**	**0.83**
34.	**2.09**	**1.01**	**2.12**	**1.06**	**2.61**	**0.83**
35.	**2.16**	**0.99**	**2.08**	**1.04**	**2.56**	**0.86**
36.	**2.09**	**0.99**	**2.24**	**1.09**	**2.54**	**0.84**
37.	**2.10**	**1.01**	**2.41**	**1.16**	**2.68**	**0.95**
38.	**2.35**	**1.09**	**2.50**	**1.15**	**2.70**	**0.93**
39.	**2.17**	**1.03**	**1.96**	**1.05**	**2.68**	**0.91**
40.	**2.15**	**0.98**	**2.15**	**0.99**	**2.49**	**0.77**
41.	**2.11**	**1.02**	**2.24**	**1.09**	**2.67**	**0.84**
42.	**2.09**	**1.05**	**2.09**	**1.12**	**2.34**	**0.82**
43.	**2.41**	**0.87**	**2.44**	**0.78**	**2.55**	**0.74**
44.	**2.24**	**0.88**	**2.02**	**0.82**	**2.73**	**0.73**
45.	**2.44**	**0.96**	**2.50**	**1.06**	**2.58**	**0.82**
46.	**2.27**	**0.89**	**2.02**	**0.92**	**2.70**	**0.78**
47.	**2.29**	**0.90**	**2.16**	**0.96**	**2.64**	**0.89**
48.	**2.07**	**0.83**	**1.95**	**0.89**	**2.71**	**0.97**
49.	**2.21**	**0.92**	**2.02**	**0.87**	**2.59**	**0.79**
50.	**2.17**	**0.92**	**2.22**	**1.02**	**2.62**	**0.86**
51.	**1.97**	**0.89**	**1.90**	**0.89**	**2.97**	**1.05**
52.	**2.02**	**0.90**	**1.85**	**0.82**	**2.39**	**0.94**
53.	**2.05**	**0.87**	**1.86**	**0.84**	**2.48**	**0.83**
54.	**2.23**	**0.91**	**2.02**	**0.94**	**2.83**	**0.87**
55.	**2.09**	**0.89**	**2.03**	**0.94**	**2.66**	**0.89**
56	**2.11**	**0.88**	**1.90**	**0.87**	**2.37**	**0.96**
57.	**2.08**	**0.90**	**1.87**	**0.85**	**2.35**	**0.91**
58.	**2.14**	**0.89**	**1.98**	**0.93**	**2.21**	**0.89**
59.	**2.55**	**0.89**	**2.44**	**0.78**	**2.49**	**0.75**
60.	**2.45**	**0.93**	**2.44**	**0.78**	**2.53**	**0.80**
61.	**2.41**	**0.93**	**2.35**	**0.74**	**2.52**	**0.79**
62.	**2.41**	**0.94**	**2.34**	**0.86**	**2.32**	**0.74**
63.	**2.40**	**0.90**	**2.17**	**0.74**	**2.21**	**0.59**
64.	**2.25**	**0.92**	**2.18**	**0.92**	**2.28**	**0.71**
65.	**2.30**	**0.95**	**2.13**	**0.86**	**2.57**	**0.82**
66.	**2.07**	**0.90**	**1.90**	**0.90**	**2.55**	**0.89**
67.	**1.88**	**0.88**	**1.91**	**0.93**	**2.34**	**0.94**
68.	**1.99**	**0.94**	**1.94**	**0.92**	**2.57**	**0.84**
69.	**2.08**	**0.91**	**2.03**	**0.92**	**2.36**	**0.75**
70.	**2.30**	**0.98**	**2.17**	**0.88**	**2.42**	**0.71**
71.	**1.98**	**0.90**	**1.99**	**0.99**	**2.86**	**0.87**
72.	**1.88**	**0.89**	**1.72**	**0.89**	**2.39**	**0.88**
73.	**1.98**	**0.85**	**1.87**	**0.99**	**2.54**	**0.84**
74.	**1.84**	**0.88**	**1.65**	**0.92**	**2.59**	**0.97**

75.	**1.89**	**0.93**	**1.72**	**0.96**	**3.11**	**1.02**
76.	**2.05**	**0.94**	**1.91**	**0.95**	**2.35**	**0.80**
77.	**2.08**	**0.92**	**2.09**	**1.02**	**2.42**	**0.79**
78.	**1.89**	**0.91**	**1.75**	**0.95**	**2.48**	**0.95**
79.	**2.08**	**0.96**	**1.82**	**0.95**	**2.57**	**0.82**
80.	**1.80**	**0.85**	**1.79**	**1.00**	**3.07**	**1.04**
81.	**1.81**	**0.90**	**1.65**	**0.91**	**2.62**	**0.89**
82.	**1.87**	**0.93**	**1.67**	**0.96**	**3.20**	**0.99**
83.	**1.79**	**0.92**	**1.64**	**0.95**	**2.86**	**0.91**

5.13 EXPERIENCE STRESSORS AND LIFE CHANGES

The response on the modified LES was subjected to the Cronbach's coefficient Alpha test and a reliability of 0.71 was obtained. This suggests that the questionnaire had good construct validity.

The LES contained a number of events which sometimes brings about change in the lives of individuals experiencing them and which necessitates social readjustment. The subjects were asked to indicate those events they had experienced within the past year. Table L lists the percentage of subjects in each group who had experienced these events.

TABLE L
EXPERIENCE OF STRESSOR PER GROUP

Event		Hospital %	Umlazi %	Kwa Mashu %	Total %
1.	Marriage	34.9	42.3	11.0	29.40
2.	Detention in jail or comparable institution	5.9	6.3	7.1	6.43
3.	Death of spouse	6.9	9.9	5.2	7.33
4.	Major change in sleeping habits (much more/less sleep)	11.2	6.1	18.8	12.03
5.	Death of close family				
	a. mother	12.0	17.4	5.8	11.73
	b. father	22.9	15.7	9.7	16.10
	c. brother	10.1	7.7	7.7	8.50
	d. sister	15.7	12.5	3.2	10.47
	e. grandmother	17.3	14.1	7.7	13.03
	f. grandfather	12.5	7.4	9.1	9.67
	g. other (specify)	10.3	6.6	16.9	11.27
6.	Major change in eating habits	13.0	10.7	16.2	13.30
7.	Foreclosure on mortgage or loan	1.8	2.3	2.6	6.70
8.	Death of close friend	22.9	15.5	15.6	18.00
9.	Outstanding personal achievement	8.8	6.9	19.5	11.73
10.	Minor law violations (traffic tickets, disturbing the peace)	6.4	3.6	3.2	4.40
11.	Male: wife/girlfriend pregnant	12.5	6.4	7.8	8.90
12.	Female: pregnant	13.9	7.2	6.5	9.20
13.	Changed work situation (different work respon-sibilty, major change in working conditions & working hours)	5.6	5.8	14.3	8.57
14.	New job	7.0	10.2	11.0	9.40
15.	Serious illness of close family member:				
	a. mother	13.3	6.9	9.7	9.97
	b. father	7.7	4.5	6.5	6.23
	c. brother	8.3	4.1	5.2	5.87

	d. sister	7.0	5.0	6.5	6.17
	e. grandmother	12.7	10.2	7.1	10.00
	f. grandfather	5.6	5.3	5.1	5.33
	g. other (specify)	3.7	3.0	8.4	5.03
	h. spouse	4.0	3.3	7.7	5.00
16.	Sexual difficulties	12.0	5.5	7.7	8.40
17.	Trouble with employer (in danger of losing job, being suspended, demoted, etc.)	4.0	2.8	4.5	3.77
18.	Trouble with in-laws	8.5	9.4	8.4	8.77
19.	Major change in financial status (a lot off or a lot worse off)	8.0	5.0	24.7	12.57
20.	Major change in closeness of family members (increased or decreased closeness).	14.9	11.6	26.0	17.5
21.	Gaining a new family member (through birth, adoption or family member moving in)	21.0	23.7	21.4	20.03
22.	Change of residence	24.2	22.1	23.3	23.20
23.	Marital separation from mate (due to conflict)	2.1	2.7	1.9	2.23
24.	Major change in church activities (increased or decreased attendance)	4.5	2.8	6.5	4.60
25.	Marital reconciliation with mate	8.3	3.9	4.5	5.57
26.	Major change with number of arguments with spouse (a lot more or a lot less arguments)	4.0	1.7	3.8	3.17
27.	Married male: Change in wife's work outside the home (beginning/ in-ceasing work, changing to new job etc.)	1.3	0.6	5.2	2.30
28.	Married female: Change in husband's work (loss of job, beginning new job,				

	retirement, etc.)		4.0		2.0		5.2	3.73
29.	Major change in usual type and/or amount of recreation		5.6		3.1		6.4	5.03
30.	Borrowing more than R10 000 (buying home, business, etc.)	3.2		4.1		14.9	7.40	
31.	Borrowing less than R10 000 (buying car, TV, getting school loan, etc.)		3.5		3.0		12.7	6.40
32.	Being fired from job		6.4		3.3		4.5	4.73
33.	Male: Wife/girlfriend having abortion	3.2		1.1		1.9	2.07	
34.	Female: Having abortion		7.5		1.4		5.8	4.90
35.	Major personal illness or injury		9.8		4.4		11.0	8.40
36.	Major change in social activities, e.g, parties, movies, visiting (increased or decreased participation)		6.1		1.6		13.0	6.90
37.	Major change in living conditions of family (building new home, remodelling, deterioration of home or neighbourhood)		28.2	17.9		17.5	21.20	
38.	Divorce		1.6		1.4		4.5	2.50
39.	Serious injury or illness of close friend	10.9		8.0		13.6	10.83	
40.	Retirement from work		2.4		1.1		2.6	2.03
41.	Son or daughter leaving home (due to marriage or college)		6.7		6.4		5.1	6.07
42.	Ending of formal school		8.0		3.0		11.6	7.53
43.	Separation from spouse (due to work or travel)		6.1		4.7		3.6	14.40
44.	Engagement	8.5		2.2		8.4	6.37	
45.	Breaking up with boyfriend/girlfriend		20.2		13.2		9.0	14.13
46.	Leaving home for the first time		9.1		5.0		9.7	7.93
47.	Reconciliation with boyfriend/girlfriend		21.3		13.2		11.6	15.37

48.	Unrest in your area*	26.3	18.3	36.3	26.97
49.	Boycotts/ strikes/ protest*	16.3	13.0	25.3	18.20
50.	House damaged/ burnt through unrest*	9.8	6.7	11.0	8.93

* new items added to the original scale

The impact of these life experiences on the subjects are found in Table LI. The minus sign indicates negative impact.

There were significant differences (chi-squared) in the way the groups perceived the extent or the impact of the following life experiences: Marriage (item 1) was regarded positively with the Umlazi Group having more of this experience than the other groups ($p<0.0001$). The Kwa Mashu Groups had the least number of marriages. However, the subjects generally found the marriage experience a positive experience. Engagement (item 44) significantly occurred more in Kwa Mashu than the other groups ($p<0.0317$). Engagements are also seen positively. Reconciliation with boyfriend or girlfriend (item 47) had a greater impact in the Hospital and Umlazi Group than the Kwa Zulu Group. The impact of marital reconciliation (item 25) was more positive in the Hospital Group. The impact of outstanding personal achievement (item 9) was significantly higher in the Kwa Mashu Group. Item 9 seemed to of had a positive impact for the subjects in this group.

The significant negative impacts were death of a spouse (item 1); change in sleeping habits (item 4); death of mother, father, sister, grandmother and other close family (item 5); serious illness of other close family member and spouse (item 15); trouble with employer (item 17); change in the number of arguments with spouse (item 26); change in husband's work (item 28); change in the amount of recreation (item 29); borrowing more than R10 000 (item 31); major personal injury (item 35); major changes in living conditions (item 37) and unrest in your area (item 48).

TABLE LI
EXTENT OF IMPACT PER GROUP

Event		Hospital	Umlazi	Kwa Mashu	p-value
1.	Marriage	0.73	1.08	0.20	0.0001
2.	Detention in jail or comparable institution	-0.09	-0.11	-0.15	NS
3.	Death of spouse	-0.12	-0.26	-0.19	0.0542
4.	Major change in sleeping habits (much more/less sleep)	-0.22	-0.09	-0.21	0.0390
5.	Death of close family				
	a. mother	-0.30	-0.51	-0.21	0.0033
	b. father	-0.57	-0.46	-0.27	0.0316
	c. brother	-0.20	-0.20	-0.26	NS
	d. sister	-0.40	-0.37	-0.10	0.0040
	e. grandmother	-0.48	-0.41	-0.18	0.0130
	f. grandfather	-0.37	-0.22	-0.27	NS
	g. other (specify)	-0.23	-0.19	-0.51	0.0004
6.	Major change in eating habits	-0.11	-0.05	-0.01	NS
7.	Foreclosure on mortgage or loan	0.00	-0.06	00.06	NS
8.	Death of close friend	-0.45	-0.28	-0.31	NS
9.	Outstanding personal achievement	0.14	0.20	0.40	0.0085
10.	Minor law violations (traffic tickets, disturbing the peace)	-0.01	-0.01	-0.03	NS
11.	Male: wife/girlfriend pregnant	0.20	0.09	0.10	NS
12.	Female: pregnant	0.11	-0.01	0.07	NS
13.	Changed work situation (different work respon-sibilty, major change in working conditions, working hours)	0.04	0.11	0.04	NS
14.	New job	0.14	0.18	0.16	NS
15.	Serious illness of close family member:				
	a. mother	-0.30	-0.19	-0.21	NS
	b. father	-0.21	-0.13	-0.16	NS

	c. brother		-0.13	-0.12	-0.07	NS
	d. sister		-0.15	-0.13	-0.20	NS
	e. grandmother		-0.24	-0.28	-0.14	NS
	f. grandfather		-0.12	-0.15	-0.05	NS
	g. other (specify)		-0.06	-0.09	-0.24	0.0059
	h. spouse		0.02	-0.09	-0.25	0.000
16.	Sexual difficulties		-0.17	-0.14	-0.14	NS
17.	Trouble with employer (in danger of losing job, being suspended or demoted)		-0.04	-0.07	-0.16	0.0668
18.	Trouble with in-laws		-0.12	-0.22	-0.21	NS
19.	Major change in financial status (a lot off or a lot worse off)	-0.07		-0.03	-0.13	NS
20.	Major change in closeness of family members (increased or decreased closeness).		-0.01	0.09	0.17	NS
21.	Gaining a new family member (through birth, adoption or family member moving in)		0.34	0.57	0.49	NS
22.	Change of residence		0.09	0.13	0.24	NS

23.	Marital separation from mate (due to conflict)	0.00	0.01	-0.06	NS
24.	Major change in church activities (increased or decreased attendance)	0.04	0.03	-0.01	NS
25.	Marital reconciliation with mate	0.18	0.10	0.06	0.0604
26.	Major change with number of arguments with spouse (a lot more or a lot less arguments)	0.08	-0.00	-0.07	0.0052
27.	Married male: Change in wife's work outside the home (beginning/ in-ceasing work, changing to new job etc.)	0.00	-0.01	-0.05	NS
28.	Married female: Change in husband's work (loss of job, beginning new job or retirement)	0.02	-0.03	-0.12	0.0061
29.	Major change in usual type and/or amount of recreation	0.08	-0.02	0.04	0.0403
30.	Borrowing more than R10 000 (buying home, business, etc.)	0.00	-0.04	0.12	0.0136
31.	Borrowing less than R10 000 (buying car, TV, getting school loan)	0.04	0.01	0.00	NS
32.	Being fired from job	-0.12	-0.08	-0.10	NS
33.	Male: Wife/girlfriend having abortion	-0.04	-0.03	-0.10	NS
34.	Female: Having abortion	-0.06	-0.04	-0.06	NS
35.	Major personal illness or injury	-0.13	-0.08	-0.28	0.0336
36.	Major change in social activities, e.g, parties, movies, visiting (increased or decreased participation)	0.01	0.02	0.12	NS
37.	Major change in living conditions of family				

	(building new home, remodelling, deterioration of home or neighbourhood)	-0.19	-0.19	0.03	0.0402
38.	Divorce	0.01	-0.02	-0.06	NS
39.	Serious injury or illness of close friend	-0.28	-0.18	-0.25	NS
40.	Retirement from work	-0.01	0.01	0.04	NS
41.	Son or daughter leaving home (due to marriage or college)	0.06	0.12	0.01	NS
42.	Ending of formal school	0.14	0.07	0.19	NS
43.	Separation from spouse (due to work or travel)	-0.10	-0.10	-0.08	NS
44.	Engagement	0.08	0.02	0.19	0.0317
45.	Breaking up with boyfriend/girlfriend	-0.30	-0.27	-0.13	NS
46.	Leaving home for the first time	-0.03	-0.03	-0.03	NS
47.	Reconciliation with boyfriend/girlfriend	0.39	0.27	0.14	0.0326
48.	Unrest in your area*	-0.53	-0.41	-0.83	0.0019
49.	Boycotts/ strikes/ protest*	-0.30	-0.26	-0.34	NS
50.	House damaged/ burnt through unrest*	-0.20	-0.19	-0.22	NS

* new items added to the original scale

A multivariate analysis of the total life experiences between the groups show a significant difference (Table XLII). The Duncan's multiple range test reveals that the difference occurs in the Umlazi Group (Table LII), that is the Umlazi Group on the average had significantly lesser life experiences or changes than the other groups.

TABLE LII
MANOVA OF TOTAL LIFE EXPERIENCES BETWEEN GROUPS

	df	SD	F	p
Group	2	15209.03	22.68	0.0001

TABLE LIII
DUNCAN'S MULTIPLE RANGE TEST

	Duncan's Grouping	Mean	N	Group
Total Life Experiences	A	49.73	376	Hospital
	A	47.84	154	Kwa Mashu
	B	40.88	362	Umlazi

A multivariate analysis of the negative and positive life experiences between groups also show a significant difference between groups (Tables LIV and LVI). The Duncan's multiple range test on negative and positive life experiences (Table LV and LVII respectively) reveals that the subjects in the Umlazi Group experienced the least amount of change compared to the other groups. These results suggest that although the Hospital Group experienced more positive and negative life experiences, it was not significantly different to the Kwa Mashu Group. Life experiences are, therefore, not a singular trigger factor to help seeking behaviour.

TABLE LIV
MANOVA OF NEGATIVE LIFE EXPERIENCES BETWEEN GROUPS

	df	SD	F	p
Group	2	2234.48	18.37	0.0001

TABLE LV
DUNCAN'S MULTIPLE RANGE TEST ON NEGATIVE LIFE EXPERIENCES

	Duncan's Grouping	Mean	N	Group
Negative Life Experiences				
	B	-12.53	343	Hospital
	B	-12.13	135	Kwa Mashu
	A	-9.05	331	Umlazi

TABLE LVI
MANOVA ON POSITIVE LIFE EXPERIENCES BETWEEN GROUPS.

	df	SD	F	p
Group	2	1722.99	9.70	0.0001

TABLE LVII
DUNCAN'S MULTIPLE RANGE TEST ON POSITIVE LIFE EXPERIENCES

Duncan's Grouping	Mean	N	Group
A	8.76	294	Hospital
A	7.87	117	Kwa Mashu
B	5.42	299	Umlazi

The discussion of these results follow in the next chapter.

CHAPTER 6

DISCUSSION

There was no significant sex or age difference in all three groups, although there were thirteen percent more females than males represented in the sample (Table I and Figure 5). This is in keeping with the sex ratio in the population according to the official census carried out in 1990. With regards to the Hospital Group the higher number of females (12.76%) is comparable to other studies on sex differences in hospital utilisation which show a generally higher use of medical care facilities by females than males. The differences range from 30% between the ages 17 to 44 and 10 to 20 % over 45 years (Nathanson, 1977; Verbrugge, 1985, 1979, Umberson, 1992). The main reason for higher utilisation of medical facilities by females have been attributed by Verbrugge, (1979) and Hibbard and Pope (1983) to the greater awareness among women of symptoms.

Most of the subjects in this study (90.71%) were between 20 to 49 years old. It is interesting that in the Hospital Group 46.50% were between the ages 20 to 29 years (Table III). This suggests that almost half the African adult patients seen at the hospital are young adults. This phenomenon is probably related to the acculturation of this community, where younger adults are more disposed to using more readily the medical facilities than the more elderly who still are more influenced by the traditional ideas of illness and health. As would be expected the majority of the sample (85.09%) were Zulu (Table IV).

There was a significant difference between the levels of education of the Hospital and community groups (Table V). These differences are depicted in Figure 7. There was a

higher level of education in the community groups than the Hospital Group. A higher percentage of the Hospital Group had no formal education (14.10%) or primary education (18.88%). This does not necessarily conflict with the available literature that suggests that there is a correlation between higher education and greater utilisation of medical facilities (Okafor, 1983). The reason for this difference is probably due to the fact that the more educated earn better and /or are on a medical aid scheme and make use of private health care facilities. Those patients that use the state hospitals are generally those that cannot afford private facilities.

There was a significant difference between the Hospital Group and the community group regarding the number of years of residence in an urban area (Table VI). A higher number of the subjects in the hospital sample had been living in an urban area for less than 10 years (24.73%) compared to Umlazi (10.77%) and Kwa Mashu (14.95%). This may support the view that the subjects in the Hospital Group may have recently moved into the urban area and therefore more likely be unemployed or without a steady income. The resulting financial constraints would force them to seek treatment provided by the state hospitals which cost considerably less.

The subjects that attended the hospital were referred from areas throughout Natal (Table VII) although the majority of the sample (80.31%) was from the areas closest to the hospital. The reasons for such a broad referral base or catchment area is that King Edward is the only teaching hospital in the province and it is also regarded as the hospital that provides the best service for African people. In some instances, even those that can afford private services prefer to attend King Edward the VIII Hospital because it is believed that being a teaching hospital 'specialist' physicians are more readily available. This perception is not only on the part of the patient but is also fostered by the local clinics who refer for specialist opinion. In addition, the lack of proper local facilities further fosters attendance at the hospital. Krige (1990) points out that some of the services provided by local clinics are inadequate; patients are expected to attend only on certain days, some services, such as, dental and psychiatric, are not provided and in some cases the demand for black services cannot be met and patients are turned away.

However, the fact that most of the sample at the hospital attended from areas, such as, Umlazi and Kwa Mashu supports the validity of comparisons between samples of the present study since these townships are representative of the community from which the Hospital Group comes.

There was a significant difference ($p<0.01$) in the occupations between the three groups. The subjects attending the hospital were found to be less skilled than those in the community groups (Table VIII). An overwhelmingly high number of the subjects in the hospital sample (72.34%) were unskilled compared to 42.82% in the Umlazi group and 18.18% in the Kwa Mashu. This again is in keeping with the view that those who cannot afford private medical health facilities or who do not have medical aid would most likely use the state health care facilities. It is also found that 42.60 percent of the hospital sample were unemployed. There are several studies that show that unemployment has a negative impact on an individuals health. Leeb and Radford (1987a, 1987b) and Radford and Leeb (1986) have shown that dismissal from work correlates with anxiety and distress after six months without work and is associated with helplessness and despondency. Moller (1988) also has shown that unemployment directly affects socio-psychological well-being.

Costs (including all constraints placed on the patient such as time or inconvenience) incurred by patients have been known to affect the utilisation of facilities (Mechanic, 1978). The patients in this study reported that the amount paid in travel to the hospital ranged from R1.00 to R52.00. Of course the amount is dependent on the distance that the patients travelled. Most of the patients in the study came from areas in and around the hospital (71.27%) and therefore the cost of travel on average was R6.27. However, when one considers that 42.60% were unemployed and that the patients still had to pay a treatment fee (minimum of R10.00 for those without income and unemployed and a minimum of R22.50 for those employed) the financial implications are not negligible. In addition, 47.60% had to take of time off from work in order to attend the hospital of which

23.46% of them will not be paid. For these individuals attending the hospital results in loss of income as well.

The cost in time varied greatly depending on the distance travelled. Some patients left home as early as 2h00 to attend the hospital. The average time spent travelling to the hospital was one hour and forty three minutes. In addition to the time spent travelling to and from the hospital, time costs are also experienced in waiting for treatment at the hospital. Although this present study did not assess the cost of time in waiting for treatment at the hospital, some patients did indicate their displeasure with the long delays experienced at the hospital (Table XVIII). Time cost is an important factor since patients leave home very early and often arrive well before the Medical Outpatient's Clinic opens. They thereafter wait in a queue to be seen by a doctor. After this screening they are most often referred to the dispensary for medication and/or for special investigations and opinions from other specialist departments. This process could take the whole day. Certain procedures, for example, a Computerised Axial Tomography (CAT) Scan, Electroencephalogram (EEG) or Electrocardiogram (ECG) may not be able to be done on the same day or in the case of other procedures such as certain blood tests or lumbar punctures the results may not be available the same day. As a result the patient may have to return to the hospital another day. Another reason for patients having to return is that sometimes other departments in the hospital may not be able to see the patient on a particular day because of their full clinic programme and gives the patient an appointment for another day. These factors further increases the cost for patients. According to Fitzpatrick and Scambler (1984), those who experience high costs, particularly through loss of time, being dependent on public transport, or lose wages for time taken off from work, are demotivated in seeking help.

6.1 HELP SEEKING BEHAVIOUR OF HOSPITAL SUBJECTS

The present study shows that the dominant reason for the choice or preference of a particular medical facility is the quality of the service provided. In the hospital sample 59%

felt that the services, facilities and /or treatments were very good, that the hospital had plenty of doctors to attend to their needs and that the hospital was also well recognised for its good treatment. This view is consistent with the views of the community groups as well regarding their reasons for the choice of services, such as, choice of doctor, the choice of hospital and the choice of a pharmacy (see Tables XI, XIII and XV). Both the community groups choose services which they perceive to be good and which were closest to them. Coppo et al (1992) have pointed out the importance of understanding the influence that distance play on help-seeking behaviour and cite studies that suggest that the critical distance is beyond 5kms.

The other reason that people seek help or utilize health care facilities are the referrals by other health facilitators, such as, general practitioners (12.00%) and peripheral hospital and clinics (10.30%) or lay referrals, such as, employers, friends and family members (7.00%). It is interesting that the lay referrals were made because those individuals as well believed that the hospital provided a better service. Lay referrals were also made by employers, friends and family. Suchman (1966) and House et al. (1988) have shown that the health seeking behaviour is a social process involving at least one other person, that lay consultation influences patterns of help-seeking and that there was a preference to consult others, such as, the police, bystanders, neighbours and friends before consulting family.

Only 2.20% acknowledged that the main reason for coming to this particular hospital was that the cost of the treatment at the hospital was far lower than that of other medical available facilities. Of course the cost referred to here is the cost of fees at the hospital and not of time, inconvenience or transport. Several studies have shown that cost is a crucial determinant of help-seeking among patients (Lewis, Fein and Mechanic, 1976; Mechanic, 1986; Mechanic, 1992)

Another factor in help-seeking that is equally important to understand is what makes an individual choose a particular time to obtain treatment. In this study, the majority of the subjects attended the hospital because they believed that their condition was

deteriorating (50.34%). Other reasons for attendance on a particular day was availability of appointments at the hospital (29.05%); no money to attend earlier (7.77%); arrangement made by other health organisations or doctors (7.10%); no time (2.70%) and no transport (2.4%). These findings are significant since they show that the majority of patients who seek medical help monitor their state and only when they believe that their condition is getting out of control do they utilise hospital services. Hence barriers such as availability of appointments, financial restraints and transport may prevent the individual from obtaining medical help when they actually believe they need it. Beside the undue stress and anxiety that this will cause, it may even further delay a condition that should have been attended to much earlier.. Mechanic (1992) has reported on the importance of lay appraisal of illness, the effect of various barriers, such as, money, time and transport, and the relationship with the doctor in influencing help-seeking.

The majority of the patients (65.40%) sought help from the hospital within a month of suspecting they were ill. This again supports the view that individuals allow a period of time for self assessment before seeking medical help. According to our findings this period for self assessment is most likely to take place within 5.85 weeks of the first suspicion of illness. Table IX and Figure 9 provide a breakdown of the time taken from the first perceptions of illness and the actual attendance at a hospital. We can infer from these results that following self-assessment most individuals will seek help within six weeks of first experiencing their symptoms.

The most common reason given by the subjects (43.50%) for not attending earlier or immediately following their first perceptions of an illness is that they felt that the illness was not serious enough to warrant medical help seeking, that they were not bothered by the symptoms.Some did not attend earlier because they had already sought medical help from a general practitioner (19.90%), had no money to attend the hospital (14.80%), treated themselves by purchasing medicines from a pharmacy (2.20%), had no transport (1.90%) and being too ill to attend (1.60%). A small percentage (1.90%) wanted to attend earlier but could not get an earlier appointment. The subject's responses for attending

earlier are consistent with the earlier responses which endorse the importance of the patients self- assessment of the seriousness of their symptoms which precipitates medical help seeking behaviour. Their responses also endorse the seeking of other services before their use of the hospital. Pharmacies and general practitioners are also sought after for medical help. For those who feel they have made no improvement help is sought from the hospital. Similar circumstances have been found to influence other societies regarding decision-making in help-seeking and treatment choice (Garbo, 1986; Good, 1986).

Another important factor to understand in medical help seeking behaviour concerns the feelings and experiences that individuals have about illness. These feelings and experiences are referred to as symptoms by medical care providers. According to the respondents 63.30% felt that they were ill because they experienced only physical symptoms while 20.80% experienced only psychological symptoms. About seventy-nine percent had experienced a combination of physical and psychological symptoms. It is interesting that subjects are able to associate psychological symptoms with indications of illness. It is commonly believed that African patients usually present with physical symptoms and very rarely present with psychological symptoms. A possible reason for this is that they may not have the psychological vocabulary to report such symptoms. Another reason is that patients reporting psychological symptoms may not be taken seriously and their presentation may be discredited as a factitious disorder or malingering. The latter is very likely to happen in overcrowded, busy hospitals like those providing care for the disenfranchised in South Africa. The failure to take psychological symptomatology seriously is, therefore, a very common phenomenon ((Eisenberg, 1986; Kellner, 1986; Mayou, 1986; Pilowsky, 1986).

The majority of subjects (87.00%) were concerned or worried about their symptoms yet 46.20% did not know what was wrong with them. However, some attributed their symptoms to a influenza (13.40%), a form of infection (12.50%) or a terminal illness (8.10%). Other lay diagnoses were also suggest, such as, 'something wrong with the blood', the bladder dirty and water in the head (5.30%). Cultural diagnoses of symptoms are also made and these include the work of the traditional healers, crossing a path where

some ritual was performed, inhaling of a bad spirit and being poisoned (3.70%). This seems to suggest that although patients are able to perceive symptoms they are unable to accurately ascribe these feeling and experiences to a particular condition. It is probably more the anxiety experienced in order to interpret these symptoms that precipitates help seeking behaviour rather than the belief that they have a particular disorder. It is, however, interesting the types of lay diagnoses made. There is an emphasis on organs or systems being dirty. Due to this belief it is not surprising that detergents are used as a form of treatment. A case in point is a parasuicide, 21 years, which was referred for a psychological evaluation following an overdose of vinegar and jeyes fluid (cattle dip). It had become subsequently evident that the patient had not taken an overdose but believed that she was poisoned by one of her colleagues who had given her some food to eat and she had subsequently fainted. When she was brought home, the neighbours and family gave her these substances in order to wash out the poison. The consequence of such beliefs, however, may have disastrous effects. Here again we see the influences of culture in attributing meaning to symptoms and remains a crucial determinant in help-seeking. (Freeman and Motsei, 1992; Sultana and Hunte, 1992).

There is evidence of a high level of self disclosure by patients about their symptoms. Eighty-six percent reported that they discussed their symptoms with others. Mothers and spouses are most often confided in. It would appear then the suggestions and recommendations made by these individuals play an important part in the decision of the patients to seek appropriate help. Suchman (1966) and House et al. (1988) have shown that the seeking of health behaviour is a social process involving at least one other person and that lay consultation influences patterns of help-seeking. People most likely to be consulted are family, neighbours and friends.

6.2 USE OF SERVICES BY COMMUNITY GROUPS

Patients most often chose doctors that were situated or located nearest to them (Table X). Their main reasons for choosing a doctor were proximity and the quality of service (Table XI). A similar pattern emerged for the choice of an hospital or a pharmacy. Subjects chose to attend the hospital closest to them, for example the subjects in Umlazi chose Prince Mshiyeni Memorial Hospital (42.50%) and King Edward VIII Hospital (35.30%) and those from Kwa Mashu chose King Edward VIII Hospital (58.40%). A possible reason for a higher number from Umlazi not attending Prince Mshiyeni Memorial Hospital (which is in Umlazi) is the political affiliation of the subjects. It is generally felt that those in Umlazi have an affiliation to the ANC and that the Prince Mshiyeni Memorial Hospital is administrated by the Kwa Zulu government which is affiliated to the IFP. Hence ANC supporters would avoid the use of such a hospital. This distrust of medical care systems have also been found amongst minority groups elsewhere, such as, Jews, Puerto Ricans and Blacks in the USA (Geertsen, et al. 1975; Lendt, 1960).

The responses gleaned suggests that the quality of the service and convenience of location play a considerable part in the utilization of health services and facilities. It is, therefore, important that these services be located within the communities they are intended to serve. This is an overhang of the political system of the country which provided racially segregated services and which not only provided inferior services for the Black but also relocated or reserved residential areas for them away from basic and essential facilities. As a result individuals have had to overcome these socio-economic barriers in order to seek medical help which has directly influenced help-seeking behaviour. In this regard, one of the hospital sample's reason given for not attending earlier “because they did not think that their illness was serious enough” could also mean that the individual had to decide whether the illness was serious enough to warrant overcoming the barriers of distance and cost. Lewis, Fein and Mechanic (1976) and Mechanic (1986) have emphasized especially the importance of accessibility of medical services in help-seeking.

Most subjects were pleased with the medical treatment received from their doctors or the hospitals they attended (Table XVI). However, a greater number of the community groups were pleased with the treatment (Umlazi 83.9% and Kwa Mashu 84.7%), than the Hospital

Group (53.2%). The greater satisfaction expressed by the community groups would probably be due to their ability to choose private doctors and clinics for their treatment where the facilities are better, more accessible and do not have to wait long for treatment. Hospital subjects, on the other hand, have no alternative but to accept the service they obtain from the overcrowded state hospitals. The writer daily observes patients attending the King Edward VIII Hospital and spend the whole day waiting without grumbling or expressing any dissatisfaction in order to be treated. These patients most often believe that the service at the hospital is a privilege and that they are not allowed to complain or be assertive.

The factors that subjects use to assess their satisfaction of treatment is the quality of the service and care given, and the cure they have had. A few assessed their satisfaction by the method of treatment (Table XVII). Table XVIII lists the aspects of treatment that subjects were not pleased with. These include the quality of the doctor-patient relationship, the quality of the facilities, the time spent to obtain treatment, the ineffectiveness of the treatment and the cost incurred. It is interesting that the community samples expressed more dissatisfaction with the quality of the doctor patient relationship, the quality with the facilities, time and cost than the hospital sample. The reason for this is that the community sample have a choice of private treatment and therefore expect the treatment to be of an acceptable standard. The hospital sample, on the other hand, expect these limitations at the state hospital because of overcrowding and over-utilization of the limited services available. It would seem that choice of services plays an important part in patient satisfaction. In addition, if people have a choice they will also demand better services. This is seen in the response by the Hospital Group who expressed dissatisfaction with the benefits of the treatment received. In other words, people who do not have the choice are unable to demand a better service and hence the service providers are not pressurized to provide a better service.

A way to rectify this situation is that health should be a right to all, that patients be allowed choice of services and that the people be empowered and educated so that they will be able to demand a reasonably good health care and service. This will also lead to an

improvement in the health services provided by the State. However, a reason for a poor service at the state hospitals is the limited services and budgets available which in turn leads to over-utilisation of certain state hospitals. For example, in South Africa the province of Natal has always been given a considerably lower health budget than the other provinces in the country. While King Edward VIII Hospital has been over-utilised and overcrowded, frequently requiring the need for floor beds, Greys Hospital (constructed for white patients) has always been under-utilised. Again this imbalance was created by the previous political policy of the country and present political reforms, it is hoped, will address these fundamental problems of inequality in order to improve both health and illness behaviour since these directly affect the health status of the whole society.

Most interviewees, however, reported that they would seek medical treatment in the future (92.2%). This indicates that the urban population have come to see and accept the need to obtain medical treatment. A small percentage did not want to (3.1%) or were not sure (4.7%). It is probably this small group that would seek alternate forms of treatments. Obviously these individuals are not totally convinced that western medicine works. Such beliefs may have also resulted either from their negative experiences of medical treatment/s or their not experiencing any benefits from such treatments besides their possible distrust of western medicine.

The use of medication is an important issue presently because of the widespread misuse or abuse that takes place. Of significance is the misuse of medication in suicidal behaviour, a growing problem in the African community (Schlebusch, 1988; Pillay, Naidoo, Tlou, 1992). Table XIX lists the sources from which subjects obtained their medication. Most subjects obtain their medication from private doctors, clinics or hospitals. Little self-prescribing takes place. Self-medicating occurred among 5.1% because they felt they had the flu and 7.7% because they experienced pain. These results suggest a lower use of over-the-counter drugs than in other populations (Schlebusch, 1988). However, because medication is obtained from medical practitioners it is important that these doctors prescribe responsibly and educate patients about the proper use of medications. Since these communities seem not to rely heavily on medication, a factor also seen in patient's

dissatisfaction of treatment were the response ‘no medication’ featured low, proper prescription will also teach appropriate medicating behaviour. This is important since only 40.4% understood why they were taking medicines. Whereas 46.8% took medication because it was prescribed without understanding the nature of the illness.
There was a significant difference (p=<0,01) in the way the hospital and community groups responded to the perceived benefits of western medicines (Table XX). More of Hospital Group found them less beneficial or were not sure about their efficacy. There could be several reasons for this discrepancy. It is very unlikely that this is the result of the quality of medications being used by the hospitals, since the standard of medication is equally good although the hospitals tend to use generic medication because of the cost of recognised trade name medicines The most likely reasons are, inaccurate medication use and/ or non-compliance with the prescribed treatment. This could be the result of patients not being given proper explanations about their illnesses (46.8% did not understand why they were taking medication), not being given proper instructions on how to take the medication (the writer has seen numerous patients who have taken suppositories orally; vaginal suppositories rectally; ear drops orally or patients, who have taken tablets prescribed three times daily only three times).

Poor doctor-patient relationships, side effects of the medication and cultural and language differences are key contributing factors to these kinds of misinterpretations. The large numbers seen at the hospitals, overcrowding, inability to speak the patient's language, lack of understanding of the patient's perceptions of illness, or the patient's understanding of illness, and time constraints directly influence the quality of instruction and information provided by medical personnel. New methods of providing such information should be considered. These could include audio and video education while patients are waiting at the hospitals; printed instruction in African languages with the use of step by step graphical illustration so the illiterate will also be able to understand; medical personnel learning the language of the people or employing skilled interpreters to disseminate information; the establishment of information centres erected in convenient spots, manned by individuals who can speak the language of the people and are familiar with the culture of the people, where patients can obtain information and help without feeling

intimidated. Implementation of such services will take the load off doctors and nurses, help improve compliance and lower the incidence of psychological problems relating to health and illness behaviour.

The use of vitamins supplements differed between the groups (Table XXI): 55.70% of the Kwa Mashu group and 40.40% of the Umlazi group used supplements. The vitamin supplements were used mainly to 'increase strength', cure or treat an illness, make one active or serve a protective function. Some also took vitamin supplements to 'strengthen the blood' or on the advise of non -medical persons. There is a higher use of vitamin supplements than medicines. This need to use such supplements may be the result of the aggressive media advertisements which promote the use of vitamin supplements as part of the health, diet and exercise fad presently in vogue.

In the earlier chapters the importance of religious and cultural beliefs and their relationship to health beliefs were discussed. A high percentage of the subjects (89.2%) were Christian, 2,8% belonged to African religious groups while 1.4% said they belonged to both Christian and traditional African religions. It is important, however to note that the large number that claimed to be Christian includes those that belong to African independent churches as well. These churches, for example the Shembe Church, integrates both African traditions and cultures with the Christian faith.

Most of the subjects denied use of traditional medicines or healers (55.37%). Subjects in the hospital and Umlazi groups tend to deny the use of these methods than was the case in Kwa Mashu. A possible explanation for this is that greater acculturation has probably taken place among the those attending the hospital and in the Umlazi Community. Faith healers are used more often than traditional healers. This is to be expected since it would be more in keeping with there religious beliefs. Wessels (1987,1989) too found that faith healers were becoming increasingly popular in the African community. Our findings are in keeping with Wessels (1987b, 1989) studies, regarding the combination of methods used in the treatment of patients by faith healers. Holy water and herbs are used more often than prayer. Prayer is usually obtained from woman prayer groups, family, friends and

neighbours (Table XXVIII). A higher number in the Kwa Mashu group responded that they had used prayer as a method of treatment for their illness.

On the average, the subjects frequented traditional healers three times and thereafter their attendance of faith healing declined (Table XXIV). This is odd because there was general consensus among those that sought such treatment that the traditional healing was helpful (60.9%). In fact more in the community perceived this kind of treatment to be beneficial than those who attended the hospital. A possible reason for this decline is either acculturation or an awareness that consulting traditional healers is not regarded as acceptable behaviour and as a result there is a reluctance to report such beliefs.

On the average 21.00% reported consulting an herbalist. It would appear from the results that subjects in the community consulted herbalist more often than those who attend the hospitals (Table XXIX). A possible reason for this is that those who attend the hospital may have a greater belief in the efficacy in western medicines or alternatively believe that the illness requires medical intervention.

Nevertheless, it is important to bear in mind that a high percentage (60.9%) do believe in the efficacy of traditional treatment and a significant number (23.3%) were ambiguous about its efficacy. In addition, 47.40% indicated that they will continue with traditional treatments (Table XXVII). This suggest that traditional treatment will still be sought and that a considerable amount of health behaviour takes place outside of the medical system. Therefore this situation has to be carefully considered when planning and providing health services to urban Africans. Failure to acknowledge their understanding and beliefs in traditional healers will result in a dualist approach to the treatment of their illness. Individuals will use medical services but will probably also secretly attend traditional healers. The fear of appearing ignorant or primitive if they express a desire to see traditional healers may lead to a delay in help-seeking behaviour and may be counterproductive if doctors are not aware of other treatments patients may be taking or, especially, if they are asked to stop medical treatment by traditional or religious healers. The author has seen several cases were patients have been asked by religious healers to

stop taking medication because their taking of medication indicates a lack of faith in God to heal them. There have also been other cases where patients have been given herbs and other substances, such as, *intelezi*, that have various psychological, psychiatric and physical symptoms. If patients do not feel comfortable sharing their beliefs about traditional and religious methods of treatment, the doctor will not be able to assist the patient promptly or efficiently. If patients do not feel that the doctor understands their beliefs or that their beliefs will be frowned upon and ridiculed, the patient will not share this information and this will lead to non-compliance with treatments prescribed by the doctor.

Subjects also reported the use of several lay or folk medicines (Table XXIX). Laxatives or purgative are used very frequently (88%). Warm water or sea water is often used to induce vomiting. A reason for this is that there is belief among Africans in the cleaning of the body and its systems. The belief is that either the organs are dirty, the blood not clean or that some thing poisonous has been ingested. However, the dangers of the use of purgative such as epsom salts, castor oil and other laxative have been frequently observed in black hospitals. The case of the 21 year old parasuicide cited earlier demonstrates belief that cleansing is needed. 'Strengthening medicines' are especially popular because they protect the individual from various omens (Wessels, 1989).

6.3 HEALTH AND ILLNESS BELIEFS (QUALITATIVE)

The subjects used a variety of symptoms or lack of symptoms and feelings to explain their understanding and meaning of being ill or well (Table XXXI, XXXII, XXXIII and XXXIV). In most cases being ill means that one does not feel good or well physically and psychologically, i.e. one does not feel normal, is worried, feels uncomfortable and not relaxed. Associated with this is pain. It is worth noting that pain rated lower in the Hospital Group (15.7%) than the community groups (32% and 39%). This probably is a result of

desensitisation to pain or that those attend the hospital bear pain stoically. Hence they do not use pain as a sign of illness but rather general well being.
Illness is also associated with being ineffective or being unproductive, having a dysphoric mood, looking ill physically, psycho-motor retardation, symptomatic and being dependent. Sleep and appetite are used to assess illness as well.

'Wellness' is considered the opposite of the 'ill' condition. An individual who is well is expected to feel good and normal both physically and psychologically. His or her mood is expected to be elated, pain free, productive and efficient, lively, active, looking good physically or healthy asymptomatic and independent. This view of health and illness is similar to those in other cultures as well; for example, Diaz-Guerrero (1984) study which included thirty different cultures. There is cross-cultural agreement that health is characterised as "good", "potent" and "active" (Diaz-Guerrero, 1984). However, he does point out that adjectives vary from one culture to another.

It is very clear from the responses of those interviewed that they adopt a holistic concept of health and illness. This is very important since there is a strong movement in western medicine as well to adopt an holistic approach to health and illness especially in view of the dichotomous relation between the mind and body assumed by the medical model (Engel, 1977; Engel, 1980; Schlebusch, 1990). If health workers do not recognise and promote this holistic concept that the African possess then they run the risk of teaching them a narrow view of illness and health out of keeping with their traditional world-view which lasts beyond several generations of acculturation. Unfortunately, the over-utilisation of services, lack of facilities, overcrowding and time constrains and poor doctor-patient care may actually promote a biological model of illness which may have to be unlearned later. Further, doctors will have to understand and treat African people holistically, otherwise their patients will not comply with the treatments prescribed.

The holistic understanding of health and illness is also seen in the reasons provided by the subjects why people get sick (Table XXXV). The most prominent reasons are poor nutrition and diets; social stress such as poor living conditions, poverty, infection and diseases,

alcohol and substance abuses; psychological stress; environmental stress, such as, violence, war unrest and occupational stresses; inherited illnesses; body malfunctioning or atrophy; preventative measures, such as, check ups; and traditional ideas, such as, bewitchment, bad terms with neighbours and family, seasonal and weather changes, and dirty organs.

Although all groups indicated that they would go to a doctor, some of the illness behaviours significantly varied among the groups;. These were for hospital attendance ($p=<0.05$), use of a pharmacy ($p=<0.01$), use of prayer ($p=<0.05$), denial ($p=<0.01$), self medication ($p=<0.01$) and reading about illnesses ($p=<0.01$). The Kwa Mashu group was less likely to attend the hospital than the other groups but more likely than the other groups to go to a pharmacy, self-medicate or deny the illness. This is probably the result of there not being a hospital near Kwa Mashu whereas Umlazi has the Prince Mshiyeni Memorial Hospital, the King Edward VIII and Clairwood Hospitals close by. This again endorses the view that the lack of facilities force individuals to seek alternate illness behaviours. Further, the Hospital Group endorsed prayer more than the community groups as a form of treatment. The Umlazi group reported that they read about illness in order to understand their illness. On the other hand, the Hospital Group responded the least to reading about their illness. This is understandable in terms of the lower level of education and lower socio-economic levels of the Hospital Group.

6.4 THE HEALTH AND ILLNESS BELIEF (QUANTITATIVE)

The reliability of this questionnaire, which was developed to measure health and illness beliefs for an African population, was 0.76. This suggests that the measurement has high internal consistency and is reliable for interpretive purposes. A comparison of the means for each of the items show that there were significant differences in the way each of the groups responded to items 1, 3, 4, 5, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, and 31.

Item 1 assessed the belief that a person gets sick because they are not strong. On this item the Hospital Group agreed more than the community groups. There was a significant difference between the three groups ($p<0.001$). Overall the respondents did agree or sometimes agree that if a person is not strong enough he or she will get sick. We could, therefore, assume that being ill means that a person is not strong enough and vulnerable and that this view will influence how they accept their illness and how others respond to them. An individual who perceives himself or herself as strong and who gets ill may therefore deny his/her symptoms for a long time and may, as a result, delay seeking help. Others associating with the person who is ill may treat him as weak. This may lead to and foster a dependent role in the patient or may lead to the patient resisting the support of those around him. There was also statistically significant differences between the Hospital Group and the Umlazi Group ($p<0.01$), and the Hospital Group and Kwa Mashu Group ($p<0.001$) This suggests that those, who attend the hospitals have a stronger belief that those who are ill are not strong. There were some who disagreed with this view ranging from 22.6% in the Hospital Group to 37.7% in the community group.

There was general agreement by all groups that a person's diet may lead to illness (item 2). This is in keeping with the reasons the subjects offered why people get sick?

The interviewees tended to disagree with the view that illness is due to desertion by God (item 3). The three groups statistically differed significantly on this belief ($p<0.001$), especially those in the Kwa Mashu Group (71.4%) who differed from the Hospital Group ($p<0.001$). Although there is agreement sometimes that it could be true, it would suggest that the general community believes this more than those who attend the hospital.

The belief that illness is caused by infection was overwhelmingly endorsed by all subjects (item 4). It is apparent, therefore, that the view of infection as a cause of illness is well accepted. However there was a significant difference between the groups' response on this item ($p<0.05$). There was also significant differences in the endorsements between the Hospital Group and the Umlazi Group ($p<0.05$), and the Hospital Group and the Kwa

Mashu Group ($p<0.05$). The Kwa Mashu Group endorsed this item overwhelmingly higher than the other groups.

Item 5 which required the subjects to respond to the belief that illness was caused by witchcraft or sorcery yielded mixed responses. There was significant differences between the three groups ($p<0.05$) as well between the Hospital Group and the Umlazi Group ($p<0.05$), and the Hospital and Kwa Mashu Group ($p<0.05$). Half of the subjects either agreed/ sometimes agree or disagreed/sometimes disagreed. Although the belief is not a dominant one, it is obviously an important belief in interpreting and understanding ones illness. With item 6, that deals with the belief that sickness is due to a curse or bewitchment by others, mixed responses were also obtained. Although there was a slightly higher tendency to disagree with such a belief.

There is general belief that lack of or inadequate regular exercise leads to ill health (item 7). A small group disagrees or are not sure of the benefits of regular exercise.

Most subjects disagreed with the belief that sickness came from the devil (item 8). On the average, 25.62% were not sure. A similar percentage agreed or sometimes agreed.

The visiting of doctors as the only help-seeking behaviour when seriously ill (item 9) was a dominant belief. Although, there were significant differences between the three groups in their agreement ($p<0.001$). All groups overwhelmingly endorsed this statement.

Most of the subjects disagreed with the belief that only doctors can treat people who are ill (item 10), this being more so in the community groups than the Hospital Group. There was significant difference between Hospital Group and Umlazi Group of $p<0.001$ and between the Hospital Group and Kwa Mashu Group of $p<0.001$. Of those who agreed, this belief was more common in the Hospital Group. This could explain why people seek medical help and may be a useful belief to consider in compliance.

Item 11 which assessed the belief that there is nothing a person can do to prevent himself from getting ill also elicited mixed responses. A statistical significance of p<0001 was obtained between the three groups. While a large number disagreed, 16.74% agreed, 21.91 % sometimes agreed and 17.19% were not sure. This would indicate that there are many who believe that they have no internal locus control in preventing themselves from getting ill (Wallston and Wallston, 1984).

Sickness as a result of poor self care and/or hygiene was endorsed by most of the subjects (item 12). A significant difference was found between the groups (p<0.05). This belief is in keeping with the subjects responses to "Why people get ill"

The subjects agree/ sometimes agreed that some illness cannot be treated by medical doctors (item 13). This would suggest then that if individuals do not believe that doctors can treat all illnesses then we could assume that they would seek help where they may feel they would obtain appropriate treatment. This belief may account for the varied response to item 10 and may lead to selective help-seeking behaviour.

The subjects also endorsed the belief that sometimes illnesses are inherited (item 14). The three groups responded differently on this item (p<0.001). The Kwa Mashu Group agreed less with this item but endorsed " sometimes agree" more often.

Item 15 which looked at self care by individuals preventing illness, was generally endorsed by the subjects. 19,21% disagreed and 15.03% were not sure. Again the issue of internal locus of control in health behaviour must be considered (Wallston and Wallston, 1984).

The subjects felt that they were able to effect a cure themselves when ill (item 16). 27.36% disagreed and 16.78% were not sure. However, they did not see themselves as culpable for illnesses (item 17). Although they sometimes agreed that their illness could be their fault. Responses significantly differed between groups (p<0.001). Here again the concept of internal locus of control may be a central issue to consider.

'Visiting a doctor for regular check ups can prevent a person getting sick' (item 18) was agreed/ sometimes agreed by most respondents However, 14.09% disagreed and 16.46% were not sure. A significant difference of $p<0.001$ between the three groups was obtained. In addition, the interviewees expressed the belief that doctors can treat symptoms but not the cause (item 19). Here again the influence of cultural and/ or traditional beliefs of illness may be discerned.

There was a generalised response to the belief that most illness can be treated at home (item 20). A significance of $p<0.001$ was obtained between the groups. 24.49% agreed, 30.70 agreed sometimes, 26.41% disagreed and 18.40% were not sure. The Kwa Mashu Group overwhelmingly disagreed with this view. Respondents also believed that older people know at lot about illness and that they can provide appropriate advice (item 21). The responses show that 29.91% agreed and 30.70% sometimes agreed with this statement.

Item 22 dealt with the belief that people should pray to God to cure them of their illness. The response varied from 27.64% agreeing, 29.44% agreeing sometimes, 22.70% disagreeing and 20.22% not sure. The three groups significantly differed in their responses ($p<0.001$).

Item 23 assessed the belief that people are lazy and do not work hard enough. Most of the subjects sometimes agreed (35.85%). A significance of $p<0.05$ between the groups was obtained.

Beliefs about the treatment given by elders or older people was assessed by item 24. The most common response was 'sometimes agree' (37.02%). The second highest response was 'not sure' (23.59%). On the average 18.17% agreed and 21.22% disagreed.
As much as 49.21% of the subjects disagreed with the belief that illness is a form of punishment for the wrong or bad things that a person has done. However, 19.41% agreed sometimes, 11.17% agreed and 20.20% were not sure.

The belief that a person may get sick as a result of something invading their body (item 25) was an accepted belief by subjects either agreeing (39.37%) or sometimes agreeing (31.79%). Only 13,46% were not sure and 15.38% disagreed with the statement. The Kwa Mashu Group showed highest agreement with the statement (49.4%) and lowest disagreement (10.4%)

Item 27 assessed the belief that sickness occurred as a result of not performing the required rituals or prayers to ancestors or priest. The groups significantly differed ($p<0.001$). Although 43.53 % disagreed with this belief, 12.04% agreed, 20.25% agreed sometimes and 24.18% were not sure. The Kwa Mashu Group least agreed with the statement (5.2%) and showed highest disagreement (59.7%).

A varied response was obtained for the belief that a person can become ill if they walk or cross over a path or place where some ritual was performed (item 28). A significant difference between groups was obtained ($p<0.05$) 'Sometimes agree' was the most common response (22.57%), while 22.57% agreed and 21.33% were not sure. 25.17% disagreed with the belief. The Kwa Mashu group demonstrated lowest agreement with this belief.

The belief that sickness is the result of malfunctioning or improper function of the body (item 29) appears to be a common belief of the respondents. Those that responded 'agree' were 34.76% and 'sometimes agree', 36.23%. The Kwa Mashu highest agreement with the statement (50.0%) and lowest disagreement (5.8%)

There was a high disagreement with the statement that illness is due to demon, evil or bad spirit possession (48.48%). A $p<0.05$ significance was obtained between the three groups. Both the community groups showed low agreement. Umlazi 9.9% and Kwa Mashu 9.7%. Although the Hospital Group demonstrated more agreement with the belief (14.9%), they also responded with the highest disagreement (51.9%).

The last item assessed the belief that illness is due to punishment or desertion by the ancestors. The respondents showed high disagreement with this belief (47.18%). Although 22.86% were not sure, 14.53% agreed and 15.43% sometimes agreed with the belief. The Kwa Mashu group indicated the lowest agreement with this belief.

While there has been significant differences in the way the interviewees responded on each item, there was no consistent difference in the way each group responded. This suggest that the Hospital Group beliefs of health and illness are not significantly different to that of the community.

However, it appears that certain dominant beliefs are endorsed by the respondents these are: people get ill because they do not eat the proper foods; illness is caused by infection, people get sick because they do not exercise regularly; people go to doctors only when they are seriously ill, people get sick because they do not keep themselves clean; there are some illnesses that doctors cannot treat; people inherit illness from their parents; if people take good care of themselves they will not get ill; people are able to cure themselves; visiting a doctor for regular check-ups can prevent a person getting sick; doctors can make the illness better but they cannot treat the cause; older people know a lot about illness and can advise others what to do; people get sick because they are lazy and do not work hard enough; people get sick when something foreign invades their bodies and sickness occurs when the body is not functioning properly. In addition, respondents generally disagreed with the following: illness is due to desertion by God; sickness comes from the devil; doctors are the only ones that can treat people who are ill; there is nothing a person can do to prevent themselves from getting ill, if a person gets ill it is their own fault; illness is a form of punishment for the wrong or bad things a person has done; sickness occurs because you do not perform the rituals or prayer required by the priest or ancestors; illness is due to demon, evil or bad spirit possession; and illness is due to punishment or desertion by the ancestors.

The beliefs that were less clear were: people get sick because they are not strong; illness is caused by witchcraft or sorcery; people get sick because someone has cursed or done

something evil to them; most illnesses can be treated at home; people should pray to God to cure them of their illness; treatment given by elders or older people can really be helpful; and a person can become ill if they walk or cross over a path or spot where some ritual was performed.

Of the nine factors that emerged, four dealt with aetiology, four addressed beliefs regarding treatment and one illness prevention. The aetiologies of illness for urban Africans according to these responses are external evil and ancestral , self-blame, medical and body malfunction or weakness. The main treatment beliefs are self medication, medical treatments, prayer and an holistic treatment approach. Self-care is seen as a method for preventing illnesses.

There were significant differences on certain factors (Table XXXIX). On factor 2, both those living in an urban area for less than 5 years and greater than 5 years endorsed the aetiological belief of self-blame (p=0.0003) but those who were living in a urban area for less than 5 years endorsed the belief of self-blame more than those who were living for greater than 5 years. A possible reason for this could be that those who lived for less than five years would have only recently left the rural areas and therefore were more likely to attribute their illness to having abandoned their cultural roots and beliefs.

On factor 3 there was a significant difference among the groups (p=0.0003) in the interaction with urbanisation. The more urbanised the individual the more likely he or she was to adopt a medical aetiology of illness. There was also significant age effect (p=0.0015). The younger the adult the more likely was he or she to adopt a medical reason for illness. This is probably due to the process of education.

Beliefs in self-medication (factor 4) significantly differed between the 3 groups (p=0.0220). These beliefs also varied with urbanisation (i.e. the number of years living in an urban area). Urbanisation also influenced the group's beliefs on body malfunction and physical weakness etiology (factor 5). This belief was also affected by the age of the individuals. The older the individual the less likely the belief. Self-care as preventative belief was

different between groups and was also influenced by urbanisation and the age of the individuals. This suggests that urbanisation and younger adults believe that self-care will prevent illnesses. The use of prayer (factor 8) varied between the groups and was influenced by urbanisation as well. Both urbanisation and age also influenced the holistic treatment belief (factor 9).

Factor 6 which deals with medical treatment varied between the groups. The community groups strongly believed in medical treatment. This would suggest that a higher level of education, acculturation and urbanisation contributes to the beliefs of the efficacy of medical treatments.

These results suggest therefore that the hospital attenders do not have a set of beliefs of health and illness different from those of the general population. Nevertheless, there are several health and illness beliefs held by this community. These beliefs are strongly influenced by urbanisation and the age of the individual. It would, therefore, seem that health and illness beliefs vary and are strongly influenced by urbanisation and age of the individuals.

6.5 SOCIAL SUPPORT AND HEALTH

This question yielded a very high level of reliability (0.91). Here again, this measurement had high internal consistency.

The responses of the subjects show that they were generally satisfied with all aspects of social support (Table XLI). Regarding accessibility, there was a significant difference among the groups as to whether the accessibility was immediate ($p=0.0001$) or delayed ($p=0.0001$). Of those that indicated that they had immediate accessibility, the Kwa Mashu Group scored highest, followed by the Umlazi Group and then the Hospital Group. For those that indicated that their accessibility was delayed, those in Kwa Mashu reported more delays than the other groups.

The proximity of the subjects' social support significantly varied for the groups (Table XLIII). Each group responded significantly differently regarding the proximity of their support. The Kwa Mashu Group mostly indicated support nearby followed by the Umlazi Group and then the Hospital Group. However, of those that indicated that their support was far, the Kwa Mashu Group had greater amount of support further away than both the Hospital or Umlazi Groups.

Regarding the mode of support, both the Hospital (80.85%) and Kwa Mashu (95.45%) groups used the telephone extensively to obtain support: Support through letter writing or postal services was obtained by 32.71% in the Hospital Group, 27.62% in the Umlazi group and 59.74% in the Kwa Mashu group. It would seem that those who attended the hospital and those living in the Kwa Mashu area have less physical contact with those who provide social support although these individuals do not live very far away. This is in keeping with the earlier results that showed that 79.26% of the hospital subjects were unaccompanied. This could be due to various socio-economic factors such as having to live separately, in relatives' homes or because those that provide social support either live with their employers, as in the case of domestics, or in hostels provided by employers. Within this context, the use of the telephone or postal services become practical. The Umlazi community, on the other hand, have more personal support and represents families living together. The fact that the subjects described their social support as being satisfactory despite the variation in the type of social support, suggests that it is not how social support is obtained but rather the availability and the perception of support by the individual that is important. The perceptions of support are probably influenced by the individual's expectations as well. In the context where the concept of family has deteriorated to the extent it has among Africans in South Africa, the individual's expectancy of social support is probably not commensurate with those of individuals in more privileged communities.

Support is most often provided by a mother, family, friends and neighbours. This is in keeping with the hospital subjects qualitative responses with regards to being

accompanied to the hospital. Of those accompanied, most were accompanied by close family and friends. Suchman (1966) and House et al. (1988) have shown that the seeking of health behaviour is a social process involving family, neighbours and friends.

The factor analysis of the responses on the social support questionnaire yielded two factors. Factor 1 deals with general social support or support in the time of a crisis. Factor 2 deals with a close, confidential type of support. It is interesting that on factor 1 the way subjects responded depended on their sex, the length of stay in an urban area and age (Table XLVI). There was no significant differences between the groups suggesting that social support did not influence help-seeking behaviour in the Hospital Group.

Females in the Hospital Group significantly endorsed the support of factor 1 more than the males ($p=0.0072$). Males endorsed this type of support in the community groups more. This may suggest that females in the Hospital Group are more satisfied generally with social support or social support in crises than those in the community. In addition, those living less than five years in the urban area were significantly more satisfied with the type of social support in factor 1 except in the case of the Umlazi Group ($p=0.0178$). This may suggest that those new in the urban area are satisfied with the social support. As they reside longer in an urban area the factor 1 type social support is perceived as being less satisfactory or the social support actually dwindles. Another reason for those living in an urban area less than five years finding the social support satisfactory, is that they may have come from rural areas where the quality of social support had been poor or non-existent. There were also significant differences in the way living in an urban area affected male's and female's perception of factor 1 social support ($p=0.0289$). The length of stay in an urban area does not seem to affect the males perception of factor one social support. After five years residence in an urban area, the females perception improved. This would suggest that females' level of social support (factor 1 type) or at least their perception of it improves when they move into an urban area.

On factor 2 there were significant differences with regards to length of stay in an urban area between the groups ($p=0.0160$) and the sex of the subjects between the groups

(p=0.0160). These differences were similar to factor 1 suggesting that the females in the Hospital Group are more satisfied generally with social support or social support in crises than those in the community (except in the Hospital Group) and that those new in the urban area are satisfied with the social support. However, as they reside longer in an urban area the factor 2 type social support is perceived as being less satisfactory or the social support actually dwindles. Here again, another reason for those living in an urban area less than five years finding the social support satisfactory is that they may have come from rural areas where the quality of social support had been poor. However, the perception of Umlazi Group's social support (factor 2 type) improved with their residence in an urban area.

Overall, the results show that there is satisfaction with the available social supports. Females seem to perceive and experience better social support than men. The improvement of the females' satisfaction with social support on factor 1, as well as the males' perceptions not declining, appears to have positive implications regarding social support and urbanisation in Africans because satisfactory social support is directly related to physical and psychological well-being and acts as a buffer between stressful life events and symptoms (Zimet et al., 1988). On the other hand, the experience and perceptions of social support on a general scale seem to decline with longer residence in an urban area. This aspect raises concern for the future. The positive effects of good social support in health and health behaviour has been well documented (Cohen and Syme, 1985; Geertsen, 1988; Ritter, 1988; Sarason, et al. 1985). However, in this study there was no significant differences between the groups. This suggests that social support did not influence help-seeking behaviour in the Hospital Group.

6.6 SYMPTOM PERCEPTIONS

A very high reliability was also obtained in this questionnaire (0.96). This suggest that the measurement has high internal consistency.

The Hospital Group did not experience more symptoms or rate their symptom as more serious than the other groups. Generally, the Kwa Mashu Group experienced more symptoms than the other groups. The subjects endorsed their experience of psychological and psychiatric symptomatology, such as, depression and anxiety together with physical symptoms. This is contrary to the popular belief that African patients do not generally present with depressive or anxiety symptomatology but mainly physical symptoms. It is possible that these individuals perceive the medical doctor as being interested in physical symptoms and therefore only report physical symptoms to him or her. This is a fundamental problem with the medical model; it focuses only on the biological. As a result, patients are taught to present their illness in this manner. Mechanic (1992) points out the influence of doctors views and practices on health and illness behaviours. The failure to address the other dimensions of health and illness, or the self-understanding within African world-view will perpetuate the seeking of alternate treatment, the delay in medical help-seeking behaviour and/ or obtaining treatment from other sources that will address the different dimensions (Freeman and Motsei, 1992). The focus on physical symptomatology will also contribute to the view that psychological, psychiatric and social symptoms are less important and the treatment of these symptoms are a luxury. Such a view results in the individual not being taken seriously or contributes to his or her learning to somatize in order to obtain help.

6.7 STRESS AND HELP SEEKING BEHAVIOUR

The reliability obtained in the modified version of the Life experience Survey was 0.71. Here again the internal consistency was high. This suggests that the questionnaire has good construct validity.

There were significant differences in the way the groups perceived the extent or impact of the following life experiences: Marriage (item 1) was regarded positively with the Umlazi Group.Its sample recorded the most marriages (p=0.0001). The Kwa Mashu Group reported the least number of marriages. However, the subjects generally found marriage a

positive experience. Engagements (item 44) were recorded in larger numbers in the Kwa Mashu Group than the other groups (p=0.0317). Engagements too are described as positive experiences. Reconciliation with boyfriend or girlfriend (item 47) had a greater impact in the Hospital and Umlazi Group than the Kwa Mashu Group. The impact of marital reconciliation (item 25) was more positive in the Hospital Group. The impact of outstanding personal achievement (item 9) was significantly higher in the Kwa Mashu Group. This too had a positive impact. The significant negative impacts were due to death of a spouse (item 1); change in sleeping habits (item 4); death of mother, father, sister, grandmother and other close family members (item 5); serious illness of other close family members and spouse (item 15); trouble with employer (item 17); change in the number of arguments with spouse (item 26); change in husband's work (item 28); change in the amount of recreation (item 29); borrowing more than R10 000 (item 31); major personal injury (item 35); major changes in living conditions (item 37) and unrest in the area of residence (item 48).

A multivariate analysis of the total life experiences between the groups show a significant difference ($p<0.001$ — Table LIII). The Duncan's multiple range test reveals that the difference occurred in the Umlazi Group (Table L). suggesting that the Umlazi Group on the average had significantly lesser threatening or enhancing life experiences or changes than the other groups. A multivariate analysis of the negative and positive life experiences between groups also show a significant difference between groups (Tables LIV and LVI). The Duncan's multiple range test on negative and positive life experiences (Table LII and LIV, respectively) reveals that the subjects in the Umlazi Group experienced the least amount of change compared to the other groups. These results suggest that although the Hospital Group experienced more positive and negative life experiences, it was not significantly different to the Kwa Mashu group. It may be inferred then that life experiences are therefore not a singularly trigger factor for help-seeking behaviour in the hospital. However, the fact that the subjects in the Hospital Group had most life changing experiences may lend some support to the relation that some have argued for between stress and illness (Feuerstein, et al., 1987; Holmes and Rahe, 1967; Rahe and Lind, 1971; Selye, 1956; Steptoe, 1991; Turton and Chalmers, 1990).

This study shows that those that attend the hospital do not have a distinctively different set of health beliefs to others in their society. What emerges is that there are several health beliefs about the aetiology, treatment and prevention. In this study the following main beliefs emerged: aetiological beliefs (external ancestral/ evil, self-blame, medical, physical weakness or body malfunction); treatment beliefs (self medication, medical, prayer, holistic treatment) and the preventative belief (self care). Age, sex, education and urbanisation strongly influence the beliefs that a person adopts. For the African patient, health, illness and disease are viewed holistically. The body and mind are inseparable from the dimensions of the social, cultural and religious. Medical beliefs are also well integrated into their conceptualisation of health and illness. There is, however, a much lesser emphasis on cultural beliefs, which is probably a result of acculturation in this community. However, this does not mean that the medical view of illness is readily accepted. There exists a belief that western medicine treats the symptoms but not the cause. Depending on the individual's belief of what the cause may be, the appropriate help-seeking takes place. This may include self-medication, seeking the help of family, traditional healers, faith healers, herbalists or prayer. This study also showed that the Hospital Group did not significantly differ from the other groups in the experience and perception of social support, the experiences and severity of symptoms and the number of life influencing experiences.

6.8 A COMPARISON OF THE RESULTS WITH OTHER HEALTH AND ILLNESS MODELS

The results of this study support many of the components or concepts proposed by some of the more popular models of health and illness. (A review of the popular models has been presented in chapter two). Those relevant aspects that emerged from this study and allow inferences to be made will be briefly discussed here. However, it must be noted that this study was not designed to test these models. Possible inferences are drawn from the results to support or validate aspects of these other models where this may be validly done..

The result of the present study supports the view that the perception of symptoms plays an important part in the seeking of help. According to the HBM, symptoms act as an internal decision making process that act as a 'cue to action'. Kasl and Cobb's Model (1966a) on illness and sick role behaviours hypothesizes that behaviour undertaken in the presence of symptoms is influenced directly by the individual's perception of the disease and the belief concerning health action. Suchman (1965a; 1965b) also points out that symptom experiences alert the individual that something is wrong which is then interpreted and results in the assumption of the sick role. Fabrega's Model (1973) also suggest that the recognition and evaluation of symptoms leads to realisation of the presence of illness and in turn leads to behaviours to alleviate them. This is also common to Mechanic's Model (1978) as well. In the present study too it was found that the presence of symptoms alerts the individual that something is wrong and precipitates the process of help seeking.

The severity of symptoms is also a component of many of these models. In keeping with the HBM, Suchman's Model (1965a, 1965b) and Mechanic's Model (1978), the extent to which symptoms are perceived as serious will affect help-seeking. This variable was also found to be one of the six categories to emerge from the Cummings, Becker and Maile (1980) study to identify common variables among the health models. In this study, severity of symptoms played a major part in precipitating help-seeking and subjects also reported that delay in seeking help was a result of them not perceiving their symptoms as serious.

'Benefits' or 'cost of action' and 'barriers' is a component that features frequently in the health models (HBM; Kasl and Cobb, 1966a; 1966b; Mechanic, 1978). Here again, subjects in this study sought help if they believed that such action would alleviate their symptoms. This study also showed the usage of several other treatments in addition to medical help-seeking. These components such as shopping, self medication, home remedies and/ or cultural treatments are also common to Suchman's Model (1965a, 1965b), Fabrega's Model (1973) and Young's model (1980)

A high percentage in this study reported seeking the help and advice of significant individuals in their environment. Suchman (1965a, 1965b), Fabrega (1973), Mechanic (1978), Young (1980) and Cummings, Becker and Maile (1980) all emphasize the importance of social support and social networks in the utilization of health facilities,

Consistent with all these models, health attitudes, values and beliefs have been found to play an important role in the perception, experience and understanding of symptoms, the choice of treatments, the decision to seek treatment and the benefits of treatments. This study is in keeping with these models also supports the view that demographic variables plays a role in the seeking of help.

The accessibility of services, as the HBM, Anderson's Model (1968) and Young (1980) also found, contributes to the utilization of health services. Responses to items such as 5, 7, 10, 11, 15, 17, 18, 19 24 and 30 on the HBQ, supports concepts such as 'health locus of control', 'internal health locus of control', 'powerful others health locus of control' and 'chance health locus of control' (Wallston and Wallston, 1984)

The fact that these results validate some of the fundamental aspects of the common health and illness models suggests that these western models may be adapted for use in the African context. Local research, like this present one, can be integrated into already existing models to provide more useful working models for local usage.

6.9 TOWARDS A MODEL OF HEALTH AND ILLNESS

Based on the findings of this study it is possible to construct a helpful model of African help seeking behaviour valid at least for communities similar to the urban African communities studied here. A graphical representation of the model is presented in Figure 12. The experiences of symptoms alerts the individual of changes taking place and commences the process of help seeking. The symptoms experienced by the patients are

both psychological and physical. As much as 63% experience physical symptoms and about 20% psychological symptoms. These symptoms that are experienced are evaluated in the context of the individual's personal conception of health and illness. This study has uncovered further evidence for the view that the urban African's conception of health and illness is holistic.

Health is viewed as feeling good, well, comfortable, free in body and mind and involves the feeling of contentment with life. The individual's mood indicates that the person is well; there is no pain; the individual is active and productive; there is normal vegetative functioning and the individual socializes appropriately. Changes in any of these will constitute illness.

These changes, that is the physical and psychological changes, as well as the cognitive evaluation of the changes, alert the individual that all is not well (this may be referred to as the stage of alertness). The individual will disclose this experience or feeling to others. About as many as 86% will share this information with others. This sharing of symptoms is referred to as illness disclosure. The purpose of illness disclosure is to help the individual make sense of his or her symptoms. Illness disclosure may also be a learned response in the individual's initial assumption of illness behaviour and sick role behaviour. The support and disclosure is most often to mother, family and friends. This is probably because mothers are generally the ones closest to the individual from birth. The experience of symptoms, is therefore, associated with the caring and nursing of a mother or mother figure and hence support will be sought from such individuals. The view that older folk know a lot about diseases will also lead to the seeking of help or support from them.

During the stage of alertness the individual tries to understand or attach meaning to the symptoms. In addition, the views of others (to whom the individual has disclosed his illness to), the individual beliefs and past experiences will also play a crucial role in establishing meaning for the symptoms.
Beliefs may be categorised into four main areas; These are, cultural, self-blame, medical or body malfunction (Table XXXIX - factors 1, 2, 3, and 5). Table XXXV provides examples of these beliefs. The experiences that assist in the understanding of the symptoms refer to those illness experiences the individual has experienced in the past and its consequences, as well as experiences of others who were ill or experiences of illness via other means such as television, newspaper, stories, oral traditions, formal education and other media.

On the basis of the meaning or understanding of these symptoms active help-seeking begins. However, as much as 46% will still not know what is wrong with them other than realise that they are ill and require help. The understanding or meanings ascribed to symptoms may be categorized into three broad areas, namely, medical, lay and/or cultural (Table XXXIX).

The help-seeking behaviours will vary. Help-seeking may be separated into four broad areas, namely, self-help, prayer, cultural and/ or medical. Self help will include the use of substances available at home, from significant others, shops and pharmacies. About 32% (Table XXXVI) will medicate themselves. The substances used may vary from homemade concoctions to medical treatments (Table XXX).

Prayer as a method of help-seeking is based on the religious view that they could be healed by God who has the power to do so. Usually prayer is obtained from members of churches or other religious organisations. Cultural treatments are obtained from the traditional healer, the faith healer and herbalist.

The use of medical services is the fourth type of treatment. However, only about 20 percent will visit a doctor immediately. About 40% will monitor their symptoms and at the point that they think that it is serious enough will they visit a doctor. In some instances the delay in visiting a doctor may be due to other barriers such as financial constraints, lack of transport, availability of appointments, sick leave and personal problems such as no baby sitters or no one to accompany the person for treatment.

Medical help-seeking is probably the result of learned behaviour, sanctioned socially accepted behaviour and the result of western influences about the understanding of illness and health. The initial reason, that is medical help seeking is a learned response, is due to several ways in which the behaviour could have been reinforced. These days, more and more African babies are being born in the hospital and not, as in the past, at home by midwives. As a result, the individual is exposed from birth to hospitals, doctors and clinics. Even pregnancy, a normal developmental process is medicalised because of the development of specialised obstetric care and the fact that a pregnancy is treated as a “disease” where the mother is required to attend ante-natal clinics. The follow up care at clinics after birth to monitor birth weight and the immunization of children further reinforces this view. Visits to the doctor and the interaction with the doctor leads to a learned response by the individual especially in a manner that is acceptable to the doctor. In this regard, patients are influenced to present symptoms to their doctors in a particular

way. This process of learning takes places through the association of symptoms with doctors, the reinforced benefits of treatment and modelling.

Other aspects that influences the choice and selection of medical services are the location and quality of the service provided. Individuals will use services located closest to them or where they believe good services are provided. Here again, the opinions of significant others play an important role in determining where good services exist.

It is important to note that the various sources of treatment, namely, self-help, prayer, cultural and medical are not necessarily mutually exclusive treatments. Individuals tend to use them concurrently. However, certain treatments may become socially sanctioned more than others. For example, with acculturation medical help seeking is more socially accepted than cultural treatments. Yet the utilization of a particular treatment may not represent complete or total treatment because there may exist the belief that doctors can treat symptoms but not the cause or that doctors are not the only ones who can treat people who are ill (HBQ item 10 and 19 respectively). Alternative treatments may then be sought but if these are not socially sanctioned it would take place clandestinely .

6.10 SUMMARY AND CONCLUSIONS

This study has demonstrated the following:

1 Urban Africans have a personal conception of illness, health and disease that influences their manner of help-seeking. Health is viewed as feeling good, well, comfortable, free in body and mind and involves one feeling content with life. The individual's mood indicates that the person is well, there is no pain, the individual is active and productive, there is normal vegetative functioning and the individual socializes appropriately. Their personal or phenomenological definition of health, illness and disease is holistic and is strongly influenced by their traditional and cultural context and experience. With westernisation and urbanisation the process

of acculturation is rapidly taking place resulting in the integration of western views on health, illness and disease with their existing view.

2 There are certain attitudes and beliefs that directly influence both positive and negative health behaviour. What emerges are several health beliefs about the aetiology, treatment and prevention. In this study the following beliefs emerged: aetiological beliefs (external ancestral/ evil, self-blame, medical, physical weakness or body malfunction); treatment beliefs (self medication, medical, prayer, holistic treatment) and the preventative belief (self care). Failure to take these beliefs into account will result in negative health behaviours. Some of these beliefs, such as, bewitchment, demon possession and body functioning attributed to “something wrong with their blood”, “dirty organs”and “water in the head”may also contribute to delays in medical help-seeking or the taking of substances that could be fatal to the individual. Self-medicating and seeking of prayer can also delay the seeking of medical treatment.

Other attitudes and beliefs that contributed to help-seeking of medical services were that the hospital provided the best services for Africans, the treatment was good and it provided the best facilities. The beliefs that the hospital is busy and crowded, illness is not serious enough, that one may get better without intervention and denial of illness also contribute to delays in seeking help.

3 The Hospital Group did not significantly differ from the other groups on health beliefs, social support, symptom perception or life experiences. This suggest that those who seek medical help do not have a peculiar profile. Rather, there are several health beliefs which interact in a complex way and may lead to medical help-seeking.

4 Health action was found to be influenced by significant individuals in the subject's environment. They are usually mothers, spouses, friends, family as well as

employers and doctors. These individuals play an important part in helping the individual understand his or her symptoms as well as the seeking of help.

5 Demographic variables, such as, age, sex, education and urbanisation strongly influence the health and illness beliefs. Younger adults, with higher education and who have lived longer in urban environments tend to use western modes of treatments more readily. With regards to sex it was found that more females attended the hospital. The hospital attenders also had lower education, moved recently to urban areas and had a significantly higher number of unemployed or unskilled.

6 These results validated some of the fundamental aspects of the common western health and illness models. This suggests that these models may be adapted for use in the African context. Local research like this one can, therefore, be integrated into research already done in order to be used locally .

7 The use of services and facilities are determined by the location, accessibility and the quality of services. Individuals will use services and facilities that are closest to them and which they perceive as providing a good service. Generally, subjects were pleased with the treatment they received at the hospitals. The aspects that subjects were not pleased about were doctor-patient relationships, poor or inadequate facilities, time delays and illness not cured.

8 There were certain barriers that negatively affected help-seeking. These were financial costs, time, transport, lack of community supports (such as, creches, lack of places to leave children in order to attend the hospital and no one to accompany those that are very ill), no early appointments available at the hospitals and other priorities, such as, work and school.

9 Symptoms have been identified as a “trigger factor” or precipitant of help-seeking. Both physical and psychological symptomatology are experienced and recognised. Almost 50 percent were not able to associate the symptoms with a disorder.

10 Patients used medications that they obtained from doctors or a pharmacy. The subjects also acknowledged the use of vitamin supplements for increasing their strength, to improve their health, make them active, protect them from illnesses and diseases and as a blood supplement.

11 Individuals use other forms of treatments independent of medical treatments. A significantly high number are Christian who use prayer and so consult traditional healers and/ or faith healers as well. Traditional or cultural treatments cost between R68.23 to R95.29. Subjects generally consult traditional healers for about three times and thereafter there is a decline in attendance. Of those that used these treatments between 40 to 80 percent found them beneficial and indicated that they will continue traditional treatment.

12 A model of help-seeking for urban Africans. This model explains the process involved in the seeking of help when ill.

These results demonstrate the importance of study of health and illness behaviour within the South African context. It is obvious that one of the important roles of the clinical psychologist in South Africa is the research and practice of psychology in health settings. This is especially important since the health system of the country is presently being dismantled because the existing health structures, which were developed on racial segregation, have now been rejected. With the announcement of the State President that health is to become a function of general affairs from the 1 April 1993 (Daily News, 30 January 1993), it is essential that in the development and re-structuring of an health system that the perspectives of clinical psychologists are taken into account. Clinical psychologists can play an important function in both policy-making and in the structuring and planing of health care facilities (from which they have been left out in the past) by applying their knowledge and skills in health psychology. Such an approach is adopted at the Sub-Department of Medically Applied Psychology, Department of Psychiatry, Faculty

of Medicine, University of Natal, Durban, where the psychologists, as part of there function at the Medical School, are involved in policy making. It is hoped that such a situation is expanded to other parts of the country.

Clinical psychologists can also play an important function in general hospitals and medical schools. In other parts of the world there has been an increase in the employment of psychologists in health related fields (Gentry and Matarazzo, 1981; Horward et al., 1986; Millon, 1982; Sweet et al. 1991). While this is still to become a trend in South Africa, the role of psychology in this country is also undergoing critical review. At the recent PASA annual general meeting there was a recommendation that the organisation disbands because of *inter alia* its lack of relevance for the present context of a changing society. While the relevance of the traditional role of psychologist may be questioned there is evidence in this present research that psychologists in this country may have a special role to play in the field of health.

This present research supports the view that, although difficult, cross-cultural research in health psychology can and must be undertaken. More research of this nature can only help to provide better care and treatment to the many in our country that have been disenfranchised. In addition, research of this kind will contribute to rapidly equalise the imbalances that presently exist. Studies of this kind will also help in the development of new as well as the standardising of, research instruments in health psychology within the South African context.

It is hoped that this present research will create interest in the area of psychology as it is applied to health and illness in South Africa. Specific areas of health and illness can be selected and studied within tightly controlled research designs thus providing insights for the treatment of Africans in this country.

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APPENDIX